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A CASE FOR ASYLUM

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Homelessness among the mentally ill has undoubtedly increased because of recent changes in assistance programs and the continuing depletion of affordable, low cost housing.[1] Our thesis, however, is that this plight is largely an expression of "social disconnectedness" in a particular segment of chronically ill mental patients which should be principally addressed through treatment strategies rather than by poverty concerns alone. This paper will present an overview of the problem. It will discuss historical antecedents, mental health system issues, current programmatic responses and consider some potential interventions.

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1. *See, e.g.*, Mowbray, *Homelessness in America: Myths and Realities* (Opinion), 55 AM. J. ORTHOPSYCHIATRY 4, 5-6 (1985).

I. INSTITUTIONALIZATION

Chronic mental illness has persisted since the beginning of recorded history.[2] When society was neither too complex nor too densely populated, the burdens of deviancy were generally sustained within the family and extended kinship systems, or even within local communities. Today many third world developing countries[3] care for their mentally ill in this fashion. As western society became increasingly secularized, technologically oriented, and urbanized, the problems presented by severe mental illness became more apparent and disruptive. These changes gave rise to the development of asylums for the mentally ill.[4] In America, confining the mentally ill has been the primary method of care for nearly 200 years.[5] Europe has used confinement for over 300 years.[6] To the extent that the problem of chronic mental illness could be isolated within an institutional context, it remained a dormant problem for society, except for periodic exposés and scathing reports of existing conditions.[7]

In his book Madness and Civilization: A History of Insanity in the Age of Reason,[8] the psycho-historian Michel Foucault

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2. For a view of mental illness in primitive, scriptural, and ancient eras, see G. ZILBOORG, A HISTORY OF MEDICAL PSYCHOLOGY 27-92 (1941). A vivid clinical description of severe mental illness is provided in the earliest and most important Hindu text on medicine (probably written between 400 and 100 B.C.), 1 CARAKA-SAMHITA 288-293 (P. Sharma ed.-trans. 1981).

3. An illustration is the work of Lambo in Africa. Lambo, *Experience with a program in Nigeria*, COMMUNITY MENTAL HEALTH: AN INTERNATIONAL PERSPECTIVE 97-110 (R. Williams & L. Ozarin eds. 1968). *Cf.* S. Pai, S. M. Channabasavanna, N. Raghuram & R. Raghuram, *Home Care for Chronic Mental Illness in Bangalore: An Experiment in the Prevention of Repeated Hospitalization*, 147 BRIT. J. PSYCHIATRY 175 (1985).

4. For varying historical perspectives, see generally M. FOUCAULT, MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON (1965); D. ROTHMAN, THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER IN THE NEW REPUBLIC (1971); G. GROB, MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875 (1973).

5. G. GROB, *supra* note 4, at ch. 2.

6. M. FOUCAULT, *supra* note 4, at 39.

7. Between 1840 and 1880, Dorothea Dix was the most ardent spokesperson and crusader for change in mental hospitals. *See* A. DEUTSCH, THE MENTALLY ILL IN AMERICA, A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES (2d ed. 1949). For other reports of conditions in mental hospitals during the same time period see *id.* at 306-07. Another notable reformer, Clifford Beers, wrote A MIND THAT FOUND ITSELF in 1908, a book based on his experience as a mental patient. *See id.* at 302-310. In the mid-1940s Albert Deutsch, a journalist, wrote about 50 articles characterizing the conditions of patients in mental hospitals across the country. *Id.* at 448-50.

8. M. FOUCAULT, *supra* note 4, at 7.

suggests that the vast numbers of empty leprosaria in Europe between the 14th and 17th centuries later provided the structures for the confinement of the insane:

> Leprosy disappeared,. . .these structures remained. Often, in these same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals, and "deranged minds" would take the part played by the leper. . . .

Prior to the nineteenth century there were very few institutions established to care solely for the mentally ill.[9] Laws for the poor usually governed the treatment of the insane, homeless, destitute, and criminals alike.[10] The socially useless were generally perceived as outcasts. Religious doctrine characterized them as sinful and evil. Prior to the era of confinement in Europe they were treated as social problems or nuisances.[11] For over one hundred years in Paris, starting in 1532, various decrees ordered that the poor be arrested, expelled from the city, whipped, driven out and finally refused entry by archers stationed at the gates.[12] In England, during the Tudor dynasty, a series of laws were passed to suppress vagrancy. For example, in 1531 a statute "provided that vagrants be whipped and returned to their homes."[13] During the reign of Elizabeth I, toward the beginning of the seventeenth century, "poor" laws were enacted which prevailed for over 200 years.[14] These laws required local communities to be responsible for poor and dependent persons,[15] and led to the development of a network of alms houses and workhouses throughout the country.[16]

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9. *Id.* at ch. VIII.

10. *See* D. ROTHMAN, *supra* note 4, at 4. *See also* M. FOUCAULT, *supra* note 4, at ch. VIII. Foucault further notes that John Howard, investigating the principal confinement centers in Europe towards the end of the 18th century, "was outraged by the fact that the same walls could contain those condemned by common law, young men who disturbed their families' peace or squandered their goods, people without professions, and the insane." *Id.* at 45.

11. M. FOUCAULT, *supra* note 4, at 58-59.

12. *Id.* at 47.

13. G. GROB, *supra* note 4, at 6.

14. *Id.*

15. *Id.*

16. *See* M. FOUCAULT, *supra* note 4, at 44; D. ROTHMAN, *supra* note 4, at 31.

Confinement for the insane, according to Foucault,[17] was an expression of the move toward secularism and the search for reason during the classical period. It was a means of concealing unreason, of instituting rational control over man. Thus, "[f]or classicism, madness in its ultimate form is man in immediate relation to his animality. . . ."[18] This view of madness contraindicated theories involving sickness or disease, and justified stern treatment of the mentally ill: "[U]nchained animality could be mastered only by *discipline* and *brutalizing*"[19] since "it becomes evident that the animal belongs rather to an anti-nature, to a negativity that threatens order and by its frenzy endangers the positive wisdom of nature."[20]

Social practices in colonial America often differed from those in England.[21] The Virginia Eastern Lunatic Asylum, established in 1769,[22] was the first mental hospital. Until 1830, however, most of the insane were informally placed with friends and families, while some lived in jails or poorhouses.[23] Places of confinement were modeled after those created under English poor laws and, initially, they were less like asylums and more like large families.[24] These facilities housed not only the poor but were developed to keep strangers, vagabonds, and other undesirable elements out of the colony.[25] Akin to Foucault's thesis that confinement served as a means to control man's natural order,[26] Rothman, a social historian, postulates that confinement in the pre-Jacksonian period functioned as a social balance to maintain the "fixity of the social order."[27]

> [T]he colonial image of society was hierarchical, with a series of ranks, upper to lower. Each segment enjoyed a fixed place with its own particular privileges and obligations. From this perspective, the community's poor, at

17. M. FOUCAULT, *supra* note 4, at 70.
18. *Id.* at 74.
19. *Id.* at 75.
20. *Id.* at 77.
21. D. ROTHMAN, *supra* note 4, at 20.
22. *Id.* at 43.
23. *Id.* at 43, 130; *see also* G. GROB, *supra* note 4, at 11.
24. D. ROTHMAN, *supra* note 4, at 42-45.
25. *Id.* at 46.
26. M. FOUCAULT, *supra* note 4, at 60-64.
27. D. ROTHMAN, *supra* note 4, at ch. 18, 126-129, 133.

> the bottom of the scale, were a permanent order, integral to the system and not a perpetual source of danger to it. As members of society, they were to respect the hierarchy and their place within it and pay proper deference to those above them. . . .[28]

Almost all of the states, twenty-eight of thirty-three, had public institutions for the insane by 1860:[29] "[T]he institutionalization of the insane became the standard procedure of the society during these years. A cult of asylum swept the country."[30] These institutions, in Rothman's view, became new mechanisms for social control.[31] They were designed to establish a new social order as the older social institutions and models of family, school, fixed social hierarchy, and parochialism had become unable to provide stability under conditions of considerable social change and social mobility.[32] In the same way that the origins of crime were within the community, the causes of mental illness were linked to social organization—they were the consequences of civilization.[33] The antidote therefore was to

> [C]reate a different kind of environment, which methodically corrected the deficiencies of the community, and a cure for insanity was at hand. This, in essence, was the foundation of the asylum solution and the program that came to be known as moral treatment. The institution would arrange and administer a disciplined routine that would curb uncontrolled impulses without cruelty or unnecessary punishment. . . .The new world of the insane would correct within its restricted domain the faults of the community and through the power of example spark a general reform movement.[34]

Between 1870 and 1880 thirty new institutions for the mentally ill were built.[35] The foundations for "custodial care", how-

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28. *Id.* at 10.
29. *Id.* at 130.
30. *Id.*.
31. *Id.* at 129.
32. *Id.* at 119-29.
33. *Id.* at 113-15.
34. *Id.* at 133.
35. G. GROB, *supra* note 4, at 303.

ever, were already laid by 1850, a form of "treatment" which persisted for one hundred years until the middle of the twentieth century.[36] Moral management emphasized a benevolent, but rigid, orderliness based upon a work ethic.[37] This design was never really compatible with a "family" model.[38] It completely broke down when the character of the institution changed, becoming overburdened with the accumulation of chronic cases and the increasing admissions of new immigrants, the poor, and seriously disturbed patients.[39] Institutions became severely overcrowded since incarceration was the principal means for dealing with deviancy. For example, the New York City Lunatic Asylum housed 278 inmates in 1840, and 1300 in 1870.[40] These conditions, coupled with limited resources and an authoritarian philosophy, led to an even more highly disciplined and militaristic regimen.[41] Repressive measures were the norm rather than the exception as institutional goals implicitly moved from patient care to order and control.[42]

Institutions continued to grow larger during the latter part of the 19th century while local control diminished and larger bureaucracies developed.[43] In many states mental hospitals became a part of the large, centralized welfare system.[44] The groundwork for the community mental health movement was established at the beginning of the twentieth century.[45] Efforts at non-institutional welfare and prison programs were initiated.[46] Clifford

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36. G. GROB, MENTAL ILLNESS AND AMERICAN SOCIETY 1875-1940, at 317 (1983).

37. D. ROTHMAN, *supra* note 4, at 144-45.

38. *Id.* at 151-52.

39. *Id.* at 265-87.

40. Grob, *Introduction* to E. JARVIS, INSANITY AND IDIOCY IN MASSACHUSETTS: REPORT OF THE COMMISSION ON LUNACY 25 (Boston 1855).

41. D. ROTHMAN, *supra* note 4, at 270.

42. *Id.* at 265, 270. For an analysis of the characteristics of authoritarian and therapeutic settings see Appleby, Smith, Ellis & Henry, *Institution-Centered and Patient-Centered Mental Hospitals: A Comparative Analysis of Polar Types*, in THE SOCIOLOGY OF MENTAL DISORDERS: ANALYSES AND READINGS IN PSYCHIATRIC SOCIOLOGY 212-18 (S. Weinberg ed. 1967).

43. G. GROB, *supra* note 4, at 292-301.

44. *Id.* at 301.

45. G. GROB, *supra* note 36, at 144-45.

46. D. ROTHMAN, CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA 3, 43 (1980), especially ch. 9 for its detailed analysis of the social influences at the turn of the century on Progressive reform views about mental illness.

Beers (himself a former patient) started the National Association for Mental Health (NAMH), and Adolph Meyers, a prominent psychiatrist, talked about "mental hygiene," outpatient and after-care programs, and also encouraged community study of the patient's surroundings.[47] Significant strides in altering institutional care for the mentally ill,however, did not really occur until the post-World War II period.

II. DEINSTITUTIONALIZATION

The development of modern psychology,[48] the advent of psychoanalysis,[49] and the branching out of psychiatry beyond institutional walls all contributed to changing views regarding the origin and treatment of mental illness during the first half of the twentieth century.[50] Although the onset of deinstitutionalization is typically fixed between the middle or late 1950s in the United States, it was not a new phenomenon.[51] Since the eighth century a unique colony for the chronically mentally ill—not unknown to psychiatrists in the post-Civil War period—existed in Gheel,

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47. *See generally id.* For accounts of the developments in the mental health movement since 1900, see G. GROB, *supra* note 36. In a related paper Grob asserts that the current role of mental hospitals has been markedly affected by increasing admissions of elderly and somatically ill patients and by internal changes in the field of psychiatry. *See* Grob, *Historical Origins of Deinstitutionalization*, in DEINSTITUTIONALIZATION 16-26 (L. Bachrach ed. 1983).

48. William James is generally credited with being the "father" of modern psychology. His *Principles of Psychology* was published in 1890. James provided the groundwork for functionalism and for a self-psychology. For an overview of his contributions, see E. BORING, A HISTORY OF EXPERIMENTAL PSYCHOLOGY 508-17 (1950).

49. Psychoanalysis was well established in this country shortly after the turn of the century. In 1909, Freud visited Clark University and presented his *Introductory Lectures on Psychoanalysis*. *See* G. ZILBOORG, *supra* note 2, at 491; A. DEUTSCH, *supra* note 7, at 489-91.

50. Two psychiatrists, Emil Kraeplin and Eugen Bleuler, were instrumental in bringing psychiatry and the study of mental illness into the scientific mold. Kraeplin, a former student of the eminent German psychologist Wilhelm Wundt, delineated specific mental diseases through his clinical studies in descriptive psychiatry; he coined the term "dementia praecox." His work influenced the thinking of Adolph Meyer. *See* A. DEUTSCH, *supra* note 7, at 485-87. Bleuler, a Swiss psychiatrist and former disciple of Freud, introduced the term "schizophrenia" in the early part of the twentieth century. He helped bridge the biological notions of Kraeplin with the psychological concepts of Freud. *See* G. ZILBOORG, *supra* note 2, at 501-02.

51. Grob suggests that the seeds for deinstitutionalization in America were developed as early as 1880. G. GROB, *supra* note 36, at 6.

Belgium.[52] The mentally ill constituted about ten percent of the population, lived with the villager caretakers, and participated in community life as regular members.[53] This remarkable community has been in existence for well over a thousand years but has never been duplicated elsewhere despite some abortive efforts.[54] A visitor during the Civil War era noted:

> It must be admitted that this spot presents a phenomenon without parallel in any part of the civilized world—that of eight hundred insane persons of different ranks, different sexes, different ages, different antecedents, and different associations, speaking different languages and presenting every form and every degree of mental alienation, yet brought under the influence of social considerations, of religious belief and practice, circulating freely and without any perceptible restraint in the midst of a population of ten thousand inhabitants, composed of Flemish peasants, simple, honest, industrious, and well-principled, scarcely conscious of the great and important service they are rendering to humanity. It affords a suggestive contemplation, to behold this colony of male and female maniacs living in complete security, and confiding trustfulness among families which have, so to speak, adopted them, enjoying with self-respect and using with discretion the liberty accorded to them.[55]

It was not until after the Second World War that dramatic changes occurred in the philosophy regarding the incarceration and treatment of the mentally ill.[56] In the postwar period a spirit of anti-colonialism and nonauthoritarianism pervaded American society.[57] The idea of anti-institutionalism was re-

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52. Many people who visited Gheel between 1850 and 1875 were apparently very impressed and as a result proposed decentralized, cottage-like institutions. *See* G. GROB, *supra* note 4, at 321-332.

53. According to Byrne, there were 800 insane persons living in the village of Gheel which had a population of 8800 people. Almost 40% of the households in Gheel proper contained boarder patients. J.C. BYRNE, GHEEL: THE CITY OF THE SIMPLE 95 (1869).

54. G. GROB, *supra* note 4, at 325-36. For a more recent effort see News and Notes, *Small Town is Foster Community for Former Patients in Missouri*, 22 HOSP. AND COMMUNITY PSYCHIATRY 58 (1971).

55. J.C. BYRNE, *supra* note 54, at 95-96.

56. G. GROB, *supra* note 36, at 6.

57. This spirit was reflected in granting independence for the Philippines in 1946 and

flected in the emerging mass media, and in the growing social concern which focused on individual freedom and human rights.[58] The *zeitgeist* of the era expressed a readiness for change, adventure, and innovation which culminated in the youthful and rebellious culture of the 1960s.[59] Confinement was no longer considered to be the most viable means of caring for the severely mentally ill; institutionalization in fact was viewed as in conflict with cultural values, and the problems it caused were viewed as *iatrogenic*.[60]

This new ethos produced several notable contributions from psychiatry and sociology. Probably the most significant—and possibly least credited—was the work of Maxwell Jones,[61] a British social psychiatrist, who believed that all aspects of hospital life were potentially therapeutic and that the social environment could alter early personality defects. In 1947, he established the Industrial Neurosis Unit at Belmont Hospital in London as a "therapeutic community." Democratization was the dominant theme, rather than authority and hospital bureaucracy.[62]

This effort resembled the search of psychiatrists in the early Jacksonian period for an "ideal" model of society which could "cure" mental illness within an institutional context.[63] There were, however, several marked variations. Rather than maintain-

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declaring statehood for Alaska and Hawaii in 1959. THE ENCYCLOPEDIA OF AMERICAN FACTS AND DATES 554, 610, 614 (G. Carruth ed. 7th ed. 1979).

58. Bachrach likens deinstitutionalization to a protest movement. L. Bachrach, *An Overview of Deinstitutionalization*, in DEINSTITUTIONALIZATION, *supra* note 47, at 5, 6.

59. A focus on this spirit of democracy was reflected in studies on authoritarianism. *See, e.g.*, T. ADORNO, E. FRENKEL-BRUNSWICK, D. LEVINSON & J.R. SANFORD, THE AUTHORITARIAN PERSONALITY (1950) and E. FROMM, ESCAPE FROM FREEDOM (1941). Riesman describes the shift in cultural values and the move to a peer-dominated society. D. RIESMAN, THE LONELY CROWD (1950). The early federally funded community mental health centers were also an expression of these times. *See, e.g.*, Slagg, Kopera & Desai, *Social Change Versus Patient Service in an Urban Mental Health Center*, 21 CURRENT PSYCHIATRIC THERAPIES 263-272 (J. Masserman ed. 1982).

60. *The Joint Commission on Mental Illness and Health, Action for Mental Health*, N.Y. ST. PSYCHOLOGICAL A. 46-49 (1962) [hereinafter *Joint Commission*]. Szasz went so far as to question whether there even was such a phenomenon as "mental illness." Szasz, *The Myth of Mental Illness* 15 AM. PSYCHOLOGIST 113-118 (1960).

61. M. JONES, THE THERAPEUTIC COMMUNITY (1953).

62. R. RAPOPORT, COMMUNITY AS DOCTOR: NEW PERSPECTIVES ON A THERAPEUTIC COMMUNIITY 275-76 (1960).

63. D. ROTHMAN, *supra* note 4, at 129.

ing a strict separation between hospital and community, the boundaries were permeable so that the "outside could be let in."[64] The environment was designed to minimize differences in order to accentuate community transition rather than to establish a new social order.[65] Concentration of power and control was withdrawn from the select few and largely distributed to both the staff and inmates of the therapeutic community.[66]

In this country, a number of developments were initiated in response to public exposure and newspaper accounts of the terrible conditions existing in state mental institutions.[67] The premise underlying most of these early ventures was that behavior is largely influenced by the environment and that many patient symptoms are a function of untherapeutic conditions in the institution.[68] Milton Greenblatt, one of the more prominent pioneers, stated that "[c]hronicity may in fact be more a function of a custodial inert atmosphere than of the disease."[69]

The efforts of social psychiatry in America paralleled many of the changes introduced by Jones in England.[70] They included a number of administrative interventions involving the reduction and minimization of the status hierarchy, the blurring of roles, the opening of communication networks, decentralization of decision making, and involvement of lower echelon personnel in the changes.[71] Programming entailed more patient participation, including patient government, resocialization, and community interaction through halfway houses and student

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64. M. JONES, *supra* note 61, at 157, 159; R. RAPOPORT, *supra* note 62, at 290.

65. M. JONES, *supra* note 61, ch. 10.

66. R. RAPOPORT, *supra* note 62, at 275-276.

67. One of the leading journalists was Albert Deutsch. *See* A. DEUTSCH, *supra* note 7, at 448-52. For an example of one of the early major efforts see M. GREENBLATT, R. YORK & E. BROWN, FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE IN MENTAL HOSPITALS (1955) [hereinafter M. GREENBLATT]. A wide range of programmatic interventions are presented in O. VON MERING & S. KING, REMOTIVATING THE MENTAL PATIENT (1957).

68. *See, e.g.*, Cumming & Cumming, *Social Equilibrium and Social Change in the Large Mental Hospital*, in THE PATIENT AND THE MENTAL HOSPITAL 49, 62 (M. Greenblatt, D. Levinson & R. Williams eds. 1957).

69. Greenblatt, *Implications for Psychiatry and Hospital Practice: The Movement from Custodial Hospital to Therapeutic Community*, in THE PATIENT AND THE MENTAL HOSPITAL, *supra* note 68, at 611.

70. M. JONES, *supra* note 61.

71. See the discussion of the "patient-centered" hospital in Appleby, Smith, Ellis, & Henry, *supra* note 42, at 212, 214-17. *See also* Greenblatt, *supra* note 69, at 615-16.

volunteers.[72]

Throughout the 1950s the mental hospital became a base of study for observational and ethnographic research by social scientists. Although traditionally their disciplines were unrelated to mental health practice, their work contributed to the continued expansion of social psychiatric developments.[73] Their findings, almost without exception, accented the deleterious effects of mental hospitals upon inmates.[74] The most influential of these was sociologist Erving Goffman.[75] In his renowned studies of mental patients, Goffman depicted the hospital as a type of "total institution" which controlled all facets of one's life.[76] He particularly alluded to the manner in which the mental hospital "captures" the self of the patient, "stripping" the individual of his identity and "forcing" him to adopt an institutional set of values and a pattern of behavior consistent with these values.[77]

Perhaps the most significant of all contributions affecting patient care was the introduction of tranquilizing drugs. Chloropromazine (Thorazine) was first used in 1952[78] and by 1956 there were already more than 4,500 reports on its use.[79] These drugs—particularly the phenothiazenes—dramatically influenced the psychotic states of the patients and the control of their behavior.[80] The tension between patient and ward personnel was markedly reduced so that a calmer, less distant, and more socially interactive climate could be generated.[81]

More than a half-million patients resided in public mental

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72. Greenblatt, *supra* note 69, at 616-18.

73. *Id.* at 618. *See also* Solomon, *Preface* to THE PATIENT AND THE MENTAL HOSPITAL, *supra* note 68, at x.

74. *See, e.g.*, Henry, *The Formal Social Structure of a Psychiatric Hospital*, 17 PSYCHIATRY 139-151 (1954); I. BELKNAP, HUMAN PROBLEMS OF A STATE MENTAL HOSPITAL (1956); H. DUNHAM & S. WEINBERG, THE CULTURE OF THE STATE MENTAL HOSPITAL (1960); E. GOFFMAN, ASYLUMS (1961).

75. E. GOFFMAN, *supra* note 74.

76. *Id.* at 6.

77. *Id.* at 20, 146-69.

78. Davis, *Antipsychotic Drugs*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1481 (H. Kaplan & B. Sadock 4th ed. 1985).

79. Von Bertalanffy, *Some Biological Consideration of the Problems of Mental Illness*, in CHRONIC SCHIZOPHRENIA: EXPLORATIONS IN THEORY AND TREATMENT 49 (L. Appleby, J. Sher & J. Cumming eds. 1960).

80. *See* J. STRAUSS & W. CARPENTER, SCHIZOPHRENIA 164, 183 (1981); J. BERNSTEIN, CLINICAL PSYCHOPHARMACOLOGY 9 (1978).

81. *See, e.g.*, M. GREENBLATT, *supra* note 67, at 82.

institutions in 1950.[82] A slow but steady decline in patient population began in 1956,[83] although deinstitutionalization did not officially begin until John F. Kennedy proposed a "bold new approach" for the treatment of the mentally disabled and Congress enacted the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.[84] The thrust of the Act was to provide a comprehensive and coordinated network of community-based services which would prevent the institutionalization of new cases of mental illness and also enable many currently hospitalized patients to return to the community. In 1965, the Act was amended to authorize funds for staffing grants and the Social Security Act was amended to allow Medicaid and Medicare programs to cover both inpatient hospital care and skilled nursing home care for the mentally ill.[85]

The impetus for this decisive move by the federal government came from the Joint Commission on Mental Illness and Health which was created by Congress in 1955 to study the treatment of mental illness in this country and to formulate new policies.[86] The Committee's recommendations were submitted to Congress in 1960 in a report entitled, "Action for Mental Health."[87]

The legislation originally projected a fifty percent reduction in state hospital populations within one or two decades.[88] The objective was actually reached in the first ten years.[89] By 1981, eighteen years after the Act was passed, the average number of daily residents in state and county mental hospitals had been

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82. Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, 34 HOSP. & COMMUNITY PSYCHIATRY 129, 132 (1983) [hereinafter Goldman].

83. *Id.*

84. Community Mental Center Act, 77 Stat. 290. *repealed by*, Omnibus Budget Reconciliation Act of 1981, Title IX, § 902(e)(2)(B), 95 Stat. 357, 560.

85. COMPTROLLER GENERAL OF THE U.S., GENERAL ACCOUNTING OFFICE, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT NEEDS TO DO MORE 207 (HRD-76-152 1977)[hereinafter GAO, *Government Needs To Do More*]. This document thoroughly describes the development of the act and presents a longitudinal history of pertinent events.

86. *Id.* at 204; *see also* G. GROB, *supra* note 36, at 317.

87. *Joint Commission*, *supra* note 60. The report by this Commission has been commonly attributed as the key precipitant in the move toward deinstitutionalization. *See, e.g.*, G. GROB, *supra* note 36, at 317.

88. GAO, *Government Needs To Do More*, *supra* note 85, at 8.

89. Goldman, *supra* note 82.

decreased by three-fourths.[90] The other major expectation was that short-term treatment would obviate the repopulation of the hospitals by chronic mental patients.[91] This objective has been realized. Even though the actual number of admissions has dropped only slightly during the past decade, the total number of psychiatric beds in state facilities has been markedly reduced (about sixty percent) because the average length of treatment time has decreased nearly fifty percent, from forty-one to twenty-three days.[92]

The drastic reductions in mental hospital populations were mainly the result of the Federal Assistance Programs. For example, the mental hospital population decreased fifteen percent between 1955 and 1965 but was reduced by sixty percent in the ten years after the fiscal legislation.[93] The accelerated depopulation of mental hospitals was largely achieved due to the availability of Medicaid and Medicare Funds for the release of thousands of chronic patients to nursing homes.[94] Estimates by the National Institute of Mental Health (NIMH) reveal that nursing homes house about one-third of the total chronically mentally ill population and provide more care for the mentally ill than any other institution.[95]

The ascendancy of the nursing home in mental health care delivery has transformed deinstitutionalization into "transinstitutionalization" or "reinstitutionalization."[96] Proportionately very few deinstitutionalized patients actually returned to independent living.[97] Life in foster care homes has been described as

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90. Survey and Systems Research Branch, Division of Biometry and Epidemiology, *NIMH, Trend Table: Number of Resident Patients, Total Admissions, Net Releases, and Deaths, State and County Mental Hospital: United States 1950-1980* (Unpublished, NIMH 1985).

91. GAO, *Government Needs To Do More, supra* note 85, at 1.

92. Department, Health & Human Services Publication No. (Adm) 85-1378, NIMH, *Mental Health United States, 1985* at 53 (1985) [hereinafter NIMH]. *See also* Goldman, *supra* note 82, at 131.

93. Goldman, *supra* note 82, at 132.

94. GAO, *Government Needs To Do More, supra* note 85, at 10-12.

95. Goldman, Gattozi & Taube, *Defining and Counting the Chronically Mentally Ill*, 32 HOSP. & COMMUNITY PSYCHIATRY 21, 25 (1981).

96. GAO, *Government Needs To Do More, supra* note 85, at 16.

97. For example, estimates of discharge outcomes in an urban hospital for 4,000 chronic mental patients released between 1960 and 1977 reveal that only 12% returned to some form of independent living; 45% were discharged to a mental health related facility or program (including 20% to nursing homes); and 36% had died, many of whom

similar to hospital life.[98] After 18 months in the community foster home residents exhibited no more improvement than patients who remained hospitalized.[99] A recent study in Germany found nursing home environments to be even more socially deleterious than mental hospital settings.[100]

A report by the General Accounting Office (GAO) in 1977 strongly indicted the government's role in deinstitutionalization. The report particularly criticized overlapping by the multiple agencies involved, and lack of coordination of their efforts.[101] It also called attention to the markedly uneven quality of care provided in nursing homes, and alluded to the possibility of simply relocating people into different institutional settings.[102] The report also cited a failure to establish standards and programmatic guidelines.[103] Perhaps the most serious point, according to the GAO, was that the Department of Health and Human Services (HHS) intended nursing home placement as an alternative only when other community resources were unavailable.[104] Furthermore, nursing homes were not intended for substantial numbers of individuals with mental disability; if fifty percent or more of their occupants had a psychiatric diagnosis the homes were considered institutions "for mental diseases" and became ineligible for Medicaid funding.[105] The potential violation of Medicaid re-

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also had probably been former nursing home residents. *See* Scheper-Hughes, *Dilemmas in Deinstitutionalization: A View from Inner City Boston*, 12 J. OPERATIONAL PSYCHIATRY 90, 93 (1981). For a summary of comparable discharge outcome studies see Minkoff, *A Map of Chronic Mental Patients*, in THE CHRONIC MENTAL PATIENT 11, 18-19 (J. Talbott ed. 1978).

98. *See e.g.*, Murphy, Pennee & Luchins, *Foster Homes: The New Back Wards?*, 71 CANADIAN MENTAL HEALTH SUPPLEMENT 1-17 (1972).

99. Murphy, Englesmann & Tcheng-Laroche, *The Influence of Foster-Home Care on Psychiatric Patients*, 33 ARCHIVES GEN. PSYCHIATRY 179, 182 (1976).

100. Kunze, *Rehabilitation and Institutionalisation in Community Care in West Germany*, 147 BRIT. J. PSYCHIATRY 261, 263 (1985). Research generally supports the finding that nursing homes provided primarily custodial care and some studies show that the residents fare no better nor worse than when they were in the mental hospital. *See, e.g.* Shadish & Bootzin, *The Social Integration of Psychiatric Patients in Nursing Homes*, 141 AM. J. PSYCHIATRY 1203, 1206-07 (1984).

101. GAO, *Government Needs To Do More*, *supra* note 85, ch.3.

102. *Id.* at 10-16.

103. *Id.* at 13-19.

104. Thus while the intent was to develop an "array of community services," *id.* at 1, the availability of medicaid funding has instead served to stimulate the development of nursing homes as the principle community resource for placement. *Id.* at 81.

105. *Id.* at 90-91.

strictions has been a bitter bone of contention and HHS has initiated measures to recover funds through disallowing Medicaid reimbursement.[106]

A recent United States Supreme Court decision[107] ruled against the State of Connecticut in favor of HHS. The Court, in effect, affirmed HHS's interpretation that the overall character of a nursing home or intermediate care facility (ICF) is markedly affected by the presence of a large number of mental patients necessitating the type of care more properly resembling that provided by an "institution for mental diseases." In the lower court's review of the legislative history, the second circuit indicated that Congress lifted the Medicaid exclusion for patients over 65 with the express intent to decrease the confinement of the elderly in mental hospitals and to encourage alternate modes of mental health care in the community.[108] The opposite was true, according to the second circuit, in the case of mental patients under 65; the application of the Medicaid exclusion was an implicit attempt to discourage the "en masse" placement of mental patients into ICF's.[109] This issue is being litigated in other states such as Illinois, Minnesota, and California.[110] It remains to be seen what impact this ruling will have on the deinstitutionalization process.[111] In any event, the ruling is a very clear statement that the federal government will not be involved in creating new institutions for the chronically mentally ill in order to facilitate deinstitutionalization.

In other cases, legal decisions may have influenced, if not accelerated, the deinstitutionalization process. Two key decisions deal with the *right to treatment* and its corollary, treatment in the *least restrictive environment*. In *Wyatt v. Stickney*,[112] the notable class action suit, the Supreme Court de-

106. *High Court Ruling Could Hurt Nursing Home Care for Mentally Ill*, 9 MENTAL HOSPITAL HEALTH REPORTS 1, 2, 8 (Virginia 1985).

107. Conn. Dep't of Income Main. v. Heckler, 731 F. 2d 1052 (2d Cir. 1984).

108. *Id.* at 1058.

109. *Id.* at 1060.

110. *Id.* at 1055. *E.g.*, Minnesota v. Heckler, 718 F. 2d 852 (8th Cir. 1983); Illinois v. Schweiker, 707 F. 2d 273 (7th Cir. 1983).

111. Rachlin, *The Influence of Law on Deinstitutionalization*, in DEINSTITUTIONALIZATION, *supra* note 47, at 41, 51. *See also* Friedman & Yohalem, *The Rights of the Chronic Mental Patient*, in THE CHRONIC MENTAL PATIENT, *supra* note 97 at 51-63 [hereinafter *Patients' Rights*].

112. 344 F.Supp. 373 (M.D. Ala. 1972).

termined for the first time that individuals involuntarily confined to mental hospitals have a constitutional right to receive treatment. The *Wyatt* court ordered the State of Alabama to insure a humane environment, a treatment plan, and appropriate staff to provide treatment. It also required the state to offer transitional care programs for released residents.[113] In the "Willowbrook" case, *New York State Association for Retarded Children, Inc. v. Carey*,[114] treatment was expanded to include a right to protection from harm caused by a noxious physical, social, and psychological environment.[115]

One implication of the *right to treatment* litigation is that programming in mental hospitals must be designed to prepare mentally handicapped individuals for community living.[116] The doctrine of the least restrictive alternative bears more directly on deinstitutionalization practices. This doctrine, based on the fundamental "right to be free from unwanted restraint,"[117] was included in the *Wyatt* decision and mandates that treatment be provided in the least restictive setting.[118] In *O'Connor v. Donaldson*,[119] the Supreme Court ruled that a state could not constitutionally confine a mentally ill person who was not dangerous and who could live safely in freedom. In *Dixon v. Weinberger*,[120] the Court stated that patients have a right to treatment in the least restrictive setting, including placement in facilities outside of the hospital.[121] The plaintiffs in this case, patients confined to St. Elizabeth's Hospital in Washington, D.C., were granted the right to receive treatment in alternative settings in the community. If such settings were unavailable, the institution was mandated to develop them. Finally, in *Thomas S. v. Morrow*,[122] budgetary constraints were deemed inappropriate reasons for not providing less restrictive treatment alternatives.[123]

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113. *Id.* at 384.
114. 393 F. Supp. 715 (E.D.N.Y. 1975).
115. *Id.* at 717.
116. *Patients Rights*, *supra* note 111, at 55.
117. Lessard v. Schmidt, 349 F. Supp. 1078, 1096 (E.D. Wisc. 1972).
118. *Wyatt*, 344 F. Supp. at 379.
119. 422 U.S. 563 (1975).
120. 405 F. Supp. 974 (D.D.C. 1975).
121. *Id.* at 978.
122. 601 F. Supp. 1055 (W.D.N.C. 1984).
123. *Id.* at 1059.

These legal decisions, as Slagg suggests, have "resulted in more stringent and formalized procedures surrounding commitment, treatment, and discharge,"[124] although their precise impact on deinstitutionalization is still to be determined. For example, more restrictive admission criteria may limit access to services for the chronically mentally ill:

> This choice between a "dangerousness" and an "in need of treatment" standard for civil commitment will obviously have profound consequences for chronic mental patients. If a dangerousness standard is accepted, and if it is defined to cover only imminent danger of serious bodily harm to self or others based upon a recent overt act, society will have no authority for intervening in the lives of many or most chronic mental patients.[125]

The doctrine of least restrictive alternative is considerably more complicated in its application that it first appears.[126] How does one actually determine that a particular setting or type of treatment is less restrictive than another? A researcher, in describing the outcome of depopulation in a Massachusetts State hospital, for example, observed that the second largest number of patients were placed "in one of many participating nursing homes—an environment, if anything, even more restrictive and institutional and lacking the grounds, canteens, and recreation rooms of the state hospital."[127]

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124. N. Slagg, Predictor Variables in Hospitalization Versus Alternative Treatments (Evanston, August 1985) (unpublished doctoral dissertation, Northwestern University at Ill.).

125. *Patients Rights*, *supra* note 111, at 52.

126. *Id.* at 55.

127. Scheper-Hughes, *supra* note 97, at 93. In a slightly different vein, a former patient at the same hospital was frequently locked up at home and could not go out by herself, but when attending the community day treatment program was free to come and go at will. Dickey, Gudeman, Hellman, Donatelle & Grinspoon, *A Follow-up of Deinstitutionalized Chronic Patients Four Years After Discharge*, 32 HOSP. & COMMUNITY PSYCHIATRY 326, 328 (1981). These observations generally correspond to the experience of the senior author. A number of years ago he was witness to the movement of 150 fairly independent elderly people from an active, open hospital setting with a variety of programs to a five-story nursing home in a very dangerous neighborhood of a large mid-Western city. Though the structure of the facility was relatively new with a decent physical plant, the residents had access only to a small fenced-in patio and were usually kept in their rooms and served meals on trays. The transfer denied them any sense of individuality experienced in their former mental wards.

Bachrach has reviewed the notion of restrictiveness in detail and has pointed out that not only is it confusing but that it is even of limited heuristic value.[128] In her analysis she indicates that the type or locale of settings can not simply be placed on a continuum of restrictiveness without considering a multiplicity of related factors.[129] Furthermore, she notes that what may be restrictive for one individual may be potentially therapeutic for another.[130]

The polemics continue: some say deinstitutionalization has never really been tried,[131] while others contend that it cannot coexist with state hospitals.[132] The particular form deinstitutionalization takes, as well as the rate of depopulation, varies among countries. In both Norway[133] and Northern Ireland,[134] for instance, there is little evidence thus far of any serious attempts to develop community alternatives. In Britain,[135] on the other hand, the decline in mental hospital beds and increases in admissions during the past decade have progressed more slowly than in the United States.

Italy has undergone the most radical form of deinstitutionalization.[136] In addition to reducing its mental hospital population, a law was passed in 1978 prohibiting the admission of ei-

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128. Bachrach, *Is the Least Restrictive Environment Always the Best? Sociological and Semantic Implications*, 31 HOSP. AND COMMUNITY PSYCHIATRY 97 (1980).

129. *Id.* at 99-100.

130. *Id.* at 99.

131. *See, e.g.*, Wolf, *Deinstitutionalization: An Idea Never Tried*, 41 THE BRIEF 5 (ACLU of Illinois, April 1985); Lipton & Sabatini, *Constructing Support Systems for Homeless Chronic Patients*, in THE HOMELESS MENTALLY ILL 153,154-55, 169 (H.Lamb ed. 1984).

132. *See* D. ROTHMAN, *supra* note 46, at 12.

133. *See* Ogar, *Recent Developments in the Care, Treatment, and Rehabilitation of the Chronic Mentally Ill in Norway*, 34 HOSP. & COMMUNITY PSYCHIATRY 349 (1983).

134. 1 Second Report from the Social Services Committee Session 1984-85, House of Commons, Community care: With special Reference to Adult Mentally Ill and Mentally Handicapped People XX (London, Her Majesty's Stationery Office January, 1985) [hereinafter House of Commons].

135. The decline, for instance, was only 30% between 1970 and 1980. *See id.* at XIX. The total reduction between 1954 and 1979 is reported to be 50%. Morris, *Recent Developments in the Care, Treatment, and the Rehabilitation of the Chronically Mentally Ill in Britain*, 34 HOSP. & COMMUNITY PSYCHIATRY 159 (1983).

136. *See, e.g.*, Mosher, *Recent Developments in the Care, Treatment, and Rehabilitation of the Chronically Mentally Ill in Italy*, 34 HOSP. & COMMUNITY PSYCHIATRY 947-950 (1983); Boffey, *Treating Mentally Ill: Trieste's Lessons*, N.Y. Times, January 17, 1984, at C2, col. 3.

ther new or former patients to "state" hospitals. Instead, since 1981, patients have been served in community-based facilities which include small psychiatric units in general hospitals.[137] These mental health centers are designed to serve catchment areas of about 100,000 people and are funded through national health insurance.[138] The law apparently has not been uniformly applied in all regions, and it is too premature to assess its effect.[139] Despite the fact, however, that the law did not specifically address depopulation, there was an eighteen percent decrease in the number of inpatients the first year; also, there was a sixty percent drop in involuntary admissions.[140] Clearly, the Italian "experiment" is as much a function of political ideology as of psychiatric thought and may not be applicable elsewhere. Outside observers have serious questions about aspects of the care provided to the chronically mentally ill.[141] One very critical paper notes that patients are "far from liberated" in the community; they have gone to forensic hospitals, prisons, and nursing homes, and "some wander the streets."[142]

In her analysis of the conceptual basis for deinstitutionalization, Bachrach indicates that it is too soon to evaluate its impact and concludes:

> First, it is frequently forgotten that deinstitutionalization, for all its positive thrust, is basically a protest movement . . . [it] is best understood as the obverse of institutionalization . . . .
>
> Second, many of the most serious problems . . . result from conceptual oversight or confusion . . . efforts have, in practice, too often confused locus of care and quality of care. Merely changing the location . . . does not in itself ensure fulfillment of the goal of humanizing mental health care.[143]

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137. Mosher, *supra* note 136, at 949.

138. *Id.*.

139. *Id.* at 950.

140. *Id.*.

141. Becker, *Psychiatric Reform in Italy—How Does it Work in Piedmont?* 147 BRIT J. PSYCHIATRY 259 (1985); Jones & Poletti, *Understanding the Italian Experience*, 146 BRIT. J. PSYCHIATRY 341, 344-347 (1985).

142. Jones & Poletti, *supra* note 139, at 344.

143. Bachrach, *A Conceptual Approach to Deinstitutionalization*, 29 HOSP. & COMMUNITY PSYCHIATRY 573, 577 (1978).

III. MENTAL HEALTH SYSTEM ISSUES

The policy of deinstitutionalization, particularly depopulation, has been practiced for over twenty years. Debate continues concerning the wisdom and merit of this plan, which has revived, under different circumstances, the treatment of the chronically mentally ill as a social problem.[144] Recidivism, nursing home scandals, overcrowded public mental hospitals, victimization, homelessness, and urban blight are commonly perceived concomitants of the shift from institution to community in the delivery of mental health services.[145] Sometimes overlooked is the fact that the large reductions in state hospital populations have frequently led to a general improvement in facility conditions.[146]

Although their present plight is different, in some respects the chronically mentally ill are no better off today than they were in the era of institutionalization. Gerald Grob, a noted mental health historian, concluded, "[i]ronically, the mentally ill became the victims rather than the beneficiaries of policies be-

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144. John Talbott has probably been the most outspoken professional regarding the plight of the chronically mentally ill. *See, e.g.*, Talbott, *Toward a Public Policy on the Chronic Mental Patient*, 50 AM. J. ORTHOPSYCHIATRY 43-53 (1980); Talbott, *The Emerging Crisis in Chronic Care* (Commentary) 32 HOSP. & COMMUNITY PSYCHIATRY 447 (July 1981).

145. Appleby, Slagg & Desai, *The Urban Nomad: A Psychiatric Problem?*, in 21 CURRENT PSYCHIATRIC THERAPIES 253 (J. Masserman ed. 1982). *See also* Minkoff, *supra* note 97, at 18-20.

146. This observation is largely based on the fact that there was a dramatic increase in the numbers of staff available to provide direct patient care following large reductions in resident populations. For example, the average daily census fell by almost two-thirds between 1969 and 1979 but the number of patient care staff was reduced by less than 20%; there were 2.3 patients for only one staff member in 1969, but by 1979 there was about one staff member for each patient. *See* National Institute of Mental Health, Mental Health United States 1983 DHHS Pub. No. (ADM) 83-127 at 23, 136. (C.A. Taube and S.A. Barrett eds.) *Compare* Goldman, Adams & Taube, *supra* note 82, at 133, who discuss the changes in treatment and in the admission and discharge policies in public mental hospitals that have resulted from the deinstitutionalization process. They point out that state hospitals now have fewer long-stay patients, are able to serve many more admissions (primarily readmissions) without increasing the number of residents, can discharge new patients more quickly, and have a wider array of discharge options in the community. A case study of deinstitutionalization at a New York State hospital between 1974 and 1978 yielded very similar findings. M. LEVINE, FROM STATE HOSPITAL TO PSYCHIATRIC CENTER 15-20 (1980); *see also* Haveliwala, *Forward* to M. LEVINE, *supra*, at XX-XVI.

lieved to have been designed for their benefit."[147] The depopulation of large public hospitals merely resulted, in many instances, in "transinstitutionalization" and the oversaturation of specific city neighborhoods with marginal and dependent individuals.[148] Furthermore, reintegration of deinstitutionalized patients into the community is not easy. In one field work project, marked regimentation was noted in the daily lives of the former patients[149] and "few ex-patients, even six years post-hospital release, had made significant inroads into the community via new friendship. . . ."[150] In another study, also from a socio-cultural perspective, clients interacted mainly with other clients when seeking equalitarian relationships.[151] The writer summarized community life for deinstitutionalized patients:

> Those patients most profoundly affected by deinstitutionalization have seen the least change. Most of them still live with other patients in places controlled by nonpatients or they live alone, perhaps in contact with their families. On the whole they are still unemployed and receive subsistence supplies based on their disabilities. They experience relative powerlessness vis-á-vis the nonpatient community and live and interact separately. Some of the more fortunate are involved in treatment programs but most are not. They are still given medication by medical personnel who believe it essential.[152]

The chronically mentally ill have almost always been served by public mental hospitals. The shift from institutionalization to deinstitutionalization has merely magnified the issue and made it more complex. Although deinstitutionalization has achieved certain goals, the advent of the community mental health movement has not appreciably affected the number of hospital admissions[153] for psychiatric services, nor has it prevented "new"

147. Grob, *Historical Origins of Deinstitutionalization*, in DEINSTITUTIONALIZATION, *supra* note 47, at 28.

148. Appleby, Slagg & Desai, *supra* note 143, at 253.

149. Scheper-Hughes, *supra* note 98, at 94.

150. *Id.* at 97.

151. Estroff, *Psychiatric Deinstitutionalization: A Sociocultural Analysis*, 37 J. SOC. ISSUES 116, 121 (1981).

152. *Id.* at 122-123.

153. In Italy, for example, there was a dramatic reduction in the number of hospital

populations of chronically mentally ill individuals.[154] Current policies and practices are thought to contribute to high rehospitalization rates [155] and to the "revolving door phenomenon."

Insufficient and inadequate resources, unable to satisfy high need and demand, have resulted in a "system imbalance."[156] One manifestation is the emergence of new chronic patients who have been receiving considerable attention. The homeless, for instance, are highly visible, repeatedly hospitalized, and apparently resistant to treatment.[157] Homelessness among former mental patients has become a major problem for the mental health system and for contemporary urban society.[158] The media, in particular, have highlighted the situation of the homeless mental patient and brought it to the attention of the public.[159]

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beds and about an 80% decrease in admissions to state hospitals between 1975 and 1980, yet the total number of annual admissions to all facilities rose more than 10%. *See* Becker, *supra* note 141, at 257. In this country Kiesler has been a vocal critic of current policy and suggests that the increasing number of admissions demonstrates the failure in translation of a national de jure policy to de facto operation. *See* Kiesler, *Public and Professional Myths About Mental Hospitalization*, 37 AM. PSYCHOLOGIST 1323, 1324 (1982). *See also* NIMH, *supra* note 92, at 8-9 for current data.

154. *See* Bachrach, *supra* note 143, at 574; Goldman, *supra* note 82, at 130; Appleby & Desai, *Documenting The Relationship Between Homelessness and Psychiatric Hospitalization*, 36 HOSP. & COMMUNITY PSYCHIATRY 732-37 (1985). An excellent clinical description of one subgroup of chronically mentally ill is offered by Schwartz & Goldfinger, *The New Chronic Patient: Clinical Characteristics of an Emerging Subgroup*, 32 HOSP. & COMMUNITY PSYCHIATRY 470-74 (1981). For insight into those chronically mentally ill who have not been hospitalized, see Pepper, Kirshner & Ryglewicz, *The Young Adult Chronic Patient: Overview of a Population*, 32 HOSP. & COMMUNITY PSYCHIATRY 463-69 (1981). Recent literature has been accruing which describes the "new" long-stay patient. *See, e.g.*, Taube, Thompson, Rosenstein, Rosen & Goldman, *The "Chronic" Mental Hospital Patient*, 34 HOSP. & COMMUNITY PSYCHIATRY 611-15 (1983).

155. *See, e.g.*, Bachrach, *supra* note 141, at 574.

156. *See* L. Appleby, Beyond Chronicity: Some Reconsiderations of Social Policy (May 1981) (Paper presented at Sixth Annual Conference of the International Association of Psycho-Social Rehabilitation Services, Arlington, Va.); Bachrach, *Asylum and Chronically Ill Psychiatric Patients*, 141 AM. J. PSYCHIATRY 975, 976-77 (1984).

157. *See* Goldfinger, Hopkin & Surber, *Treatment Resisters or System Resisters?: Toward a Better Service System for Acute Care Recidivists* in ADVANCES IN TREATING THE YOUNG ADULT CHRONIC PATIENT 17-27 (B. Pepper & H. Ryglewicz eds. 1984); Appleby, Slagg & Desai, *supra* note 145, at 254; Bachrach, *The Concept of Young Adult Chronic Psychiatric Patients: Questions from a Research Perspective*, 35 HOSP. & COMMUNITY PSYCHIATRY 573-80 (1984).

158. For example, the American Psychiatric Association created a special task force to investigate the problem. *See* THE HOMELESS MENTALLY ILL, *supra* note 131.

159. *See, e.g.*, Anderson, *U.S. Creating Psychiatric Ghettos*, Washington Post, Feb. 11, 1978 at E39; Herman, *New York City Psychiatric Wards Overflow as Albany Changes its Mental Health Role*, N.Y. Times, Dec. 8, 1980, at B1, col. 5; Elliot, *Mental*

In addition to regular coverage in the newspapers, the major television networks have produced special programs on the homeless, ABC's *Nightline* having aired several yearly productions. Indeed, homelessness is even a topic for the socially conscious cartoonist Garry Trudeau in his *Doonesbury* comic strip.

There are conflicting estimates of the number of homeless individuals in this country.[160] Figures from "reputable" sources range from HUD's 250,000 to Community for Creative Non-Violence's 3,000,000;[161] NIMH employs an estimate of 2,000,000 homeless.[162] The lack of uniform criteria and consistent definitions, as well as marked variations in methodology, pose serious limitations in generalizing about the actual number of homeless people. Furthermore, the methods employed cannot accurately identify the homeless population without considerable expense and, at best, probably result in an undercount. For example, many episodically homeless individuals would be excluded from a cross-sectional or time-sampling approach; only about a fourth of the homeless seem to be continuously without shelter.[163] Also, a number of people are not readily found; they may be living in cars, doorways, under bridges, in tunnels or subways. Others may even be unidentified deaths in morgues or recent burials in pauper cemeteries.[164] Finally, delimited definitions of homeless-

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Patients Released to Streets, Houston Post, Feb. 18, 1978 at 12A, col. 1. Both TIME and NEWSWEEK have also quite recently raised issues about the homeless mentally ill. Krauthammer, *When Liberty Really Means Neglect*, TIME, Dec. 2, 1985 at 103, 104; Morganthau, *Abandoned*, NEWSWEEK, Jan. 6, 1986 at 14.

160. U.S. DEPT. OF HOUSING AND URBAN DEVELOPMENT, A REPORT TO THE SECRETARY ON THE HOMELESS AND EMERGENCY SHELTERS 18 (1984) [hereinafter HUD, *The Homeless and Emergency Shelters*].

161. *Id.* at 9.

162. Shiffren-Levine, *Homelessness: Its Implications for Mental Health Policy and Practice*, 8 PSYCHOSOCIAL REHABILITATION J. 6, 7 (1984).

163. There are some variations in the number of chronically homeless persons reported by different cities. *See* HUD, *The Homeless and Emergency Shelters, supra* note 160, at 29-30. A survey in New York City revealed, for instance, that nearly half of a group of shelter residents had been homeless for more than two years. NEW YORK CITY REGIONAL OFFICE, NEW YORK STATE OFFICE OF MENTAL HEALTH, WHO ARE THE HOMELESS?: A STUDY OF RANDOMLY SELECTED MEN WHO USE THE NEW YORK CITY SHELTERS 30-31 (May 1982)[hereinafter *Men Who Use the New York City Shelters*].

164. Only a small percent of the 350 people buried annually in the Chicago area Potter's field are listed without an "official" address. It is difficult to determine, from available information, how many were actually residentially unsettled. However, they were clearly poor and socially isolated individuals; no one was willing to pay for a funeral. Telephone interview with spokesperson from the Medical Examiner's office of Cook

ness frequently exclude individuals who are residentially unstable and lack permanent addresses. In a recent survey of homeless people in Ohio, the latter constituted twenty-five percent of the sample.[165]

Materials originating outside this country are even more sketchy concerning the scope of homelessness as well as the homeless mentally ill. At a recent conference designed to address growing economic instability throughout Europe, groups working with the homeless reported "a dramatic increase in the number of evictions, a growing percentage of homeless who have been thrown out of their homes, and a trend toward seeing younger and younger people living on the streets."[166] In Britain, the number of people defaulting on their mortgages has multiplied fivefold since 1979,[167] and there are estimates of 140,000 homeless people;[168] an astonishing rise from the 30,000 homeless single persons reported in a government survey published in 1966.[169] In Paris, 10,000 people are thought to be "living on the streets," and the number of vagrants seeking night lodging has doubled to 40,000 since 1971.[170] Government figures indicate a twenty-eight percent increase in evictions from rental units in Italy; twenty percent of young couples live with relatives after the birth of their first child.[171] In Denmark, 20,000 people are estimated to be homeless, including a substantial increase in the

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County in Chicago (Feb. 24, 1986).

165. D. ROTH, J. BEAN, N. LUST & T. SAVEANU, HOMELESSNESS IN OHIO: A STUDY OF PEOPLE IN NEED 76 (Ohio Department of Mental Health 1985) [hereinafter D. ROTH]. In our view emphasis on obtaining an accurate count of the homeless is a spurious problem motivated more by political rather than by programmatic need. It often eventuates into conflict between bureaucracies and service providers. If the issue was addressed properly, the focus would not be on homelessness but would instead be on the general framework of poverty. Thus, if 33,000,000 people or one out of every 7 Americans are living below the government defined standard for poverty, then it is more than likely that some proportion of this population is going to be hungry, unemployed, homeless, etc. In these terms, the needs of the homeless would automatically be encompassed by a comprehensive policy which attends to all individuals at a poverty level existence.

166. Thomas, *The Homeless of Europe: A Scourge of Our Time*, N.Y. Times, Oct. 7, 1985 at A2, col. 2 [hereinafter *The Homeless of Europe*].

167. *Id.*

168. *Id.*

169. *See* Priest, *The Edinburg Homeless: A Psychiatric Survey* 25 AM. J. PSYCHOLOGY 195 (1971).

170. *The Homeless of Europe*, *supra* note 164.

171. *Id.*

number of those under thirty years of age.[172] The plight of an estimated 1200 homeless persons in Dublin has been mounting in visibility and receiving considerably more attention from voluntary agencies and government officials.[173]

Nevertheless, despite the methodological complications, the incidence of homelessness among the severely mentally ill has apparently risen substantially over the past decade and is minimally estimated at three to four times that of the general population.[174] Reports indicate marked increases in psychiatric admissions of homeless individuals[175] and have identified as mentally ill a significant number in residents of shelters for the homeless.[176] Researchers have concentrated their recent efforts on varied groups of homeless people, conducting surveys on the streets, in shelters, or at soup kitchens in an attempt to determine the pervasiveness of mental illness.[177] A very ambitious survey in Ohio[178] focused on homeless individuals from urban and rural areas living in a variety of settings including the streets, missions, jails, and cheap hotels. Although marked variations occur in the estimates of mental illness in these studies, a substantial number of the subjects—probably about one-

172. *Id.*

173. Kearns, *Homelessness in Dublin: An Irish Urban Disorder*, 43 AM. J. ECON. & SOC. 217, 231 (1984).

174. *See* Appleby & Desai, *supra*, note 154, at 736.

175. *See, e.g.*, Lipton, Sabatini & Katz, *Down and Out in The City: The Homeless Mentally Ill*, 34 HOSP. & COMMUNITY PSYCHIATRY 817, 818 (1983).

176. *See* Arce, Tadlock, Verage & Shapiro, *A Psychiatric Profile of Street People Admitted to an Emergency Shelter*, 34 HOSP. & COMMUNITY PSYCHIATRY 814 (1983) [hereinafter Arce]; Bassuk, *The Homeless Problem*, 251 SCI. AM. 40, 42 (1984).

177. *See, e.g.*, Arce, *supra* note 176; Bassuk, *supra* note 176; MULTOMAH COUNTY DIVISION OF SOCIAL AND AGING SERVICES, THE HOMELESS POOR: 1984 (1984); UNIVERSITY OF MARYLAND SCHOOL OF SOCIAL WORK AND COMMUNITY PLANNING, THE SERVICE NEED OF SOUP KITCHEN USERS (1983); PHOENIX SOUTH COMMUNITY MENTAL HEALTH CENTER, THE HOMELESS OF PHOENIX: WHO ARE THEY? AND WHAT SHOULD BE DONE? (1983) [hereinafter PHOENIX SOUTH]; *Men Who Use the New York City Shelters, supra* note 163; A. STEVENS, L. BROWN, P. COLSON & K. SINGER, WHEN YOU DON'T HAVE ANYTHING: A STREET SURVEY OF HOMELESS PEOPLE IN CHICAGO (Chicago Coalition for the Homeless 1983)[hereinafter A. STEVENS]. Two very recent surveys were conducted, one in New York City and the other in Chicago, both of which used objective measures in assessing the mental health status of the homeless: E. STRUENING, A STUDY OF RESIDENTS OF THE NEW YORK CITY SHELTER SYSTEM, ch. 4 (New York State Psychiatric Institute, 1986); Rossi, Wright, Fisher & Willis, *The Urban Homeless: Estimating Composition and Size*, 235 SCIENCE 1338-39 (April 1986). *See also* HUD, *The Homeless and Emergency Shelters, supra* note 160, at Appendix B (for a comprehensive annotated bibliography).

178. D. ROTH, *supra* note 165.

third—appear to have had previous psychiatric histories.[179] Using National Institute of Mental Health (NIMH) projections, Levine[180] estimates that one-half of the nation's 2,000,000 homeless are suffering from some form of severe mental disorder.

Although most studies are oriented to determining the proportion of the homeless who are mentally ill, a few researchers have addressed the issue of what proportion of the mentally ill are homeless. From examinations of individuals at the point of psychiatric evaluation or soon after admisssion, they have reached a different perspective from which the results are consistent.[181] A high percentage of the homeless applying for services are former psychiatric patients[182] and are hospitalized with excessive frequency.[183] As in the data from shelters, the homeless mentally ill were found to be young, isolated, predominately male, and to have had extensive involvement with the police.[184] Virtually the same results have been obtained by investigations in Ireland[185] and Scotland.[186]

In the United States, more importance may be placed on this issue than in other countries. Concern has been growing abroad, as shown by this recent report from England.

> [I]t may be that the scale of the problem is less serious. But there are hundreds if not thousands of mentally ill people living unsupported in the community, many of

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179. This figure represents the authors' estimate of the average or model percent.

180. Shiffren-Levine, *supra* note 162, at 7.

181. *See, e.g.*, Appleby, Slagg & Desai, *supra* note 145; Appleby & Desai, *supra* note 154; Lipton, Sabatini & Katz, *supra* note 173; Chafetz & Goldfinger, *Residential Instability in a Psychiatric Setting*, 56 PSYHIATRIC Q. 20-34 (1984).

182. *See, e.g.*, Lipton, Sabatini & Katz, *supra* note 175, at 819.

183. Appleby & Desai, Homelessness, Residential Instability, and Chronic Recidivism 4 (Chicago, Ill. 1985)(unpublished study).

184. Appleby, Slagg and Desai, *supra* note 145, at 254-57; Appleby and Desai, *supra* note 154, at 736.

185. J. Fernandez, "In Dublin's Fair City" The Mentally Ill of "No-Fixed-Abode" 11-12 (Lecture at Conference on Homelessness)(Dublin Sept. 1983).

186. Priest, *The Homeless Person and the Psychiatric Services, An Edinburgh Survey* 128 BRIT J. PSYCHIATRY 128, 134 (1976). It should be mentioned that the definition of homelessness in Great Britain is broader than the one commonly used in our country and refers to people residing in an "unsettled way of life." Thus, individuals who may be long-term residents of hostels or paying guests in lodging houses would be considered homeless. A recent survey included individuals "living in a situation of no security and tenure" and without a "settled base." *See* Drake, O'Brien & Biebuyck, Single and Homeless 125 (Her Majesty's Stationery Office, London 1985) [hereinafter Drake].

> them former hospital patients. Large numbers are sleeping rough in archways and under railway bridges, some within hailing distance of the Palace of Westminster. Many more are in hostels for the single homeless. These are the often invisible victims of past and present deficiencies in community care.[187]

Homelessness among the mentally ill is more common in urban areas and seems most prevalent in those countries which have stressed deinstitutionalization policies.[188] Findings are generally consistent with the studies in the United States. For example, about one-fourth to one-third of the shelter residents in Britain have had psychiatric histories.[189] The increasing number of homeless mentally ill is largely attributed to discharge pressures stemming from rising admissions and decreasing availability of beds. An epidemiological study of homeless people in Edinburgh also revealed a high percentage of psychiatric diagnoses, usually schizophrenia, when compared to earlier research which showed that alcoholism was the predominant cause of their condition.[190] In Turin, Italy about twelve percent of 1500 discharges following the new law in 1978 were "unknown," many probably homeless and estimates placed "a hundred to several hundred homeless ex-patients" in the metropolitan area.[191] Finally, in Dublin, most of the comparatively small number of homeless people are considered to "suffer emotional and psychological disorders;" approximately one-third are diagnosed schizophrenic and about one-quarter are alcoholics.[192] The number of homeless psychiatric admissions doubled between 1972 and 1975, but has since remained relatively constant.[193]

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187. HOUSE OF COMMONS, *supra* note 134, at LXXXIII-LXXXIV.

188. This is an observation based on the available literature reported in this paper. *Cf.* Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899 (1984).

189. *See* HOUSE OF COMMONS, *supra* note 134, at LXXXIV. A current survey of homeless, single persons, however, indicates that only 17% had psychiatric histories, although nearly half of the sample had been institutionalized and about 25% of referrals to an agency were from mental institutions. *See* Drake, *supra* note 186, at 68.

190. R. Priest, *supra* note 186, at 133.

191. Becker, *supra* note 141, at 260.

192. Kearns, *supra* note 173, at 237.

193. Fernandez, *supra* note 185, at 11.

IV. Social Disconnectedness

Homelessness amongst the mentally ill is not new. Recent economic changes, more restrictive assistance programs, and the decreasing availability of room and board facilities and similar forms of cheap housing, have exacerbated and heightened its visibility.[194] However, these factors alone do not explain why some chronic mental patients become homeless and others do not. For example, Bassuk notes from her observations on shelter residents that,

> [c]hronic mental illness, even when it is severe enough to impair the ability to function in society, does not by itself cause homelessness, any more than unemployment does. For the great majority of shelter guests lack of a home is symptomatic of total disconnection from supportive people and institutions.[195]

The recent recession and high unemployment have frequently been linked to increases in homelessness although there is no supportable evidence of their impact on chronic psychiatric patients.[196] The mentally disabled (perhaps not their families) are probably less directly affected by unemployment levels than other groups and it is doubtful that their poverty rate changes significantly from year to year.[197] Homelessness among the mentally ill increased substantially during the past decade, yet the poverty rate was relatively stable and even slightly lower between 1970 and 1979.[198] Despite higher levels of poverty in 1983 and 1984, the rate of poverty increased about 10 percent be-

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194. Mowbray, *supra* note 1, at 5-7. *See also* Bassuk, *supra* note 176, at 41.

195. Bassuk, *supra* note 176, at 43.

196. *Id.* at 41.

197. *Cf.* Mowbray, *supra* note 1, at 6-7. Talbot indicates that while up to half of the discharged patients return to work (primarily to a less-skilled job) only about a fourth are still working after a year. Talbott, *Toward a Public Policy*, *supra* note 144, at 45. We are suggesting, that while unemployment and poverty levels may be fluctuated considerably between 1970 and 1985, the same trends would not likely be apparent in a population of psychiatric admissions to a public mental hospital. Minkoff indicates, for example, that about 25% of former patients are employed "regardless of length of follow-up." Minkoff, *supra* note 97, at 24.

198. Bureau of the Census, U.S. Dept. of Commerce, Current Population Reports, Series P-60, No. 147, *Characteristics of the Population Below the Poverty Level: 1983* at 5 (1985).

tween 1980 and 1984,[199] however, the percentage of homeless admissions to state facilities in Illinois rose almost 25 percent during this same period of time.[200] Even more noteworthy is that the increase in homeless admissions to mental hospitals over the last fifteen years virtually parallels the rising rates of readmission.[201] Inferentially this suggests that as the number of psychiatrically unsettled individuals increases there is a corresponding increase in the rate of homelessness.

Changes in the housing market, possibly more than any other single factor, may account for increasing homelessness.[202] Bassuk[203] notes that while the number of renter households with income below $3,000 fell by half between 1970 and 1980, the number of rental units available at thirty percent of their income fell seventy percent. The median rent rose from $72.00 to $179.00 monthly. The growing number of evictions and mortgage defaults in European countries[204] would tend to confirm the widening gap between available income and affordable housing, and its potential impact on residential stability among families. A survey of the single homeless in Britain indicates that homelessness is most prevalent in unstable communities and in communities where limited low-cost housing is available.[205] The authors concluded that "*an increase in provision of single person accommodation generally vitally underpins any approach to dealing with single homelessness and preventing longer term homelessness.*"[206]

A most crucial factor for the chronically mentally ill homeless has been the dramatic reduction by closure, conversion, or redevelopment of single-room occupancy hotels (SRO), room

199. *Id.*; Bureau of the Census, U.S. Dept. of Commerce, Current Population Reports, Series P-60, No. 149, *Money Income and Poverty Status of Families and Persons in the United States: 1984* at 3 (Advance Data From the March 1985 Current Population Survey).

200. Unpublished data from Office of Information Services, Illinois Department of Mental Health and Developmental Disabilities (Springfield, Illinois Oct. 1985).

201. Office of Information Services, Illinois Dept. of Mental Health and Developmental Disabilities, Fiscal Year 1984 Annual Statistics at 119 (Springfield, Illinois, Nov. 1984).

202. *See* 4 N.Y.L. SCH. HUM. RTS. ANN. (Spring and Fall 1986).

203. Bassuk, *supra* note 176, at 41.

204. *The Homeless of Europe*, *supra* note 166.

205. Drake, *supra* note 186, at 13-14.

206. *Id.* at 108.

and board facilities, and other types of low-cost housing over the last ten to fifteen years. A joint study conducted by New York and Columbia Universities reveals that about one million rooms, approximately half of the SRO's in this country, were lost between 1970 and 1980.[207] In New York City, there were only 18,000 SRO units in 1982,[208] an eighty-seven percent loss in total units from the 110,000 which existed in 1970.[209] Chicago has lost over half of its 30,000 units over the last ten years.[210] Furthermore, a survey of Chicago SRO hotels in 1983 indicated that the monthly cost per room was more than $190.00; renters received a mere $144.00 from the General Assistance grant and, if eligible, an additional $75.00 in food stamps.[211] The more restrictive criteria for Social Security Disability Insurance (SSI) and the inadequate levels of Public Aid assistance have probably contributed most to the inability of the chronically mentally ill to compete economically for a scarce resource, namely, low-cost housing.[212]

Although poverty indices can provide a partial explanation, the relationship between chronic mental illness and homelessness is complex. Levine suggests that the kinds of behaviors typically accompanying chronic mental illness are frequent barriers to employment and housing opportunities.[213] The process of deinstitutionalization has not supplied sufficient resources to address these problems. Furthermore, the present philosophy of rapid discharge places added social burdens on families[214] and other support systems without adequate time for homeostatic regrouping. From this perspective, it is primarily the circumstance of chronic mental illness which leads to homelessness. Homelessness can be considered the most tenable outcome of a situation in which individuals have lived in disruptive settings

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207. Saffrin & Goldberg, *Cities Reclaim SRO Housing*, 8 THE NEIGHBORHOOD WORKS 1, 12 (Center for Neighborhood Technology, Chicago, Sept. 1985). *See also* Baxter & Hopper, *Shelter and Housing for the Homeless Mentally Ill*, in THE HOMELESS MENTALLY ILL, *supra* note 131, at 109, 113 (H. Lamb ed. 1984).

208. Lipton, Sabatini & Katz, *supra* note 175, at 821.

209. Baxter & Hopper, *supra* note 207, at 113.

210. Saffrin & Goldberg, *Apartment Hotels at Risk*, 8 THE NEIGHBORHOOD WORKS 7, 12 (Center for Neighborhood Technology, Chicago, Oct. 1985).

211. Stevens, *supra* note 177, at 8.

212. Mowbray, *supra* note 1, at 6.

213. Levine, *supra* note 160, at 8-9.

214. *Cf.* Goldman, *Mental Illness and Family Burden: A Public Health Perspective*, 33 HOSP. & COMMUNITY PSYCHIATRY 557 (1982).

over a period of time and have lost the benefit of support networks. Thus, homelessness among the mentally ill is not simply a condition or an abrupt event. More probably, it is the final, though not necessarily fixed, stage in a process of social disconnectedness. The pathways to homelessness merely reinforce their sense of impotency and augment their alienation. Kearns suggests that homeless individuals in Dublin "were often social isolates long before they became adult homeless."[215] He describes the following process:

> [T]hough each homeless individual has his own personal experience of deprivation and disaffiliation, several salient problems are commonly shared: unstable childhood, limited education, family stress, marital strife, health or psychological disorders, lack of occupational skill, and prolonged unemployment. The process of homelessness normally involves "push-pull" forces in which an individual is gradually rejected by, or withdraws from, normative society and is attracted to the homeless milieu. This process of disaffiliation, estrangement and alienation is consistent with Merton's anomie theory in which an individual reacts and adjusts to the disjuncture between socially prescribed goals and expectations and the available means of actually achieving them. Most of Dublin's homeless, suffering from some combination of the above cited problems, are unable to cope with stress and fulfill expectations; thus, they become rejects or retreatists, losing family and social bonds and seeking haven in a marginal, but tolerant, community within the inner-city.[216]

Some sociologists regard homelessness as "a condition of detachment from society characterized by the absence or attenuation of the affiliative bonds that linked settled persons to a network of interconnected social structures."[217] This condition reflects the attachment pathology of the homeless mentally ill which is expressed in an inability to maintain social bonds and

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215. Kearns, *supra* note 173, at 220.

216. *Id.* at 219, 220.

217. H. BAHR & T. CAPLOW, OLD MEN DRUNK AND SOBER 5 (1973).

their persistent flight from routine and structured situations.[218] Elsewhere we have characterized homeless and highly mobile mental patients as "urban nomads" whose lifestyle is that of a "floater," one who constantly gravitates toward the more anonymous, transitional, and marginal areas of the city and those communities more accepting and tolerant of deviance.[219] Most of the homeless mentally ill are psychologically fragile, impoverished persons who have limited capacity to either cope with stress or to utilize social supports; their "condition of homelessness reflects multiple disabilities."[220]

Residential instability is a much larger problem than homelessness among the chronically mentally ill. Conceptually, residential instability enables one to examine both the adaptive and maladaptive behavior of chronic mental patients as they move between stable and unstable living arrangements, homelessness constituting one extreme. From a slightly different perspective,

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218. Appleby, Slagg, & Desai, *supra* note 145, at 254-55.

219. *Id.* at 254.

220. Bachrach, *Disability Among the Homeless Mentally Ill* in PSYCHIATRIC DISABILITY; CLINICAL, ADMINISTRATIVE AND LEGAL ASPECTS 7 (A.T. Meyerson & T. Fine eds. 1987).

Psychoanalytic Theory helps in understanding the link between the impoverishment and attachment pathologies of chronic mental illness and the extreme state of social disconnectedness in homelessness. It provides a psychological model which suggests that such deviations in adulthood stem from faulty experiences earlier in life and are principally the result of disturbances in self-selfobject relationships. John Bowlby, a pioneer in the study of attachment behavior states that "the representational models a person builds of his attachment figures and also the form in which his attachment behavior becomes organized are the results of learning experiences . . . the first year of life and . . . repeated almost daily throughout childhood and adolescence." J. BOWLBY, ATTACHMENT AND LOSS: LOSS 55, ch. 3 (1980).

In THE RESTORATION OF THE SELF (1977), Kohut expands upon this thesis in his concepts of self-selfobject relationships, visualizing the unfolding of a capacity for attachment through a series of early mutually enhancing and "need-satisfying" experiences. *Id.* at 88-89. An environment which continually responds inappropriately (i.e., provides "emphatic failures") leads to the development of an enfeebled, weak, and vulnerable self—possibly emotionally impoverished throughout life. *Id.* at 189. He notes that proper mirroring "if optimally experienced during childhood . . . remains one of the pillars of mental health throughout life and, in the reverse, if the self-objects of childhood fail, then the resulting psychological deficits or distortions will remain a burden that will have to be carried throughout life. *Id.* at 87-88. "Man," according to Kohut, "lives in a matrix of selfobjects from birth to death. He needs selfobjects for his psychological survival, just as he needs oxygen in his environment throughout his life for physiological survival." Kohut, *Reflections on Advances in Self Psychology*, in ADVANCES IN SELF PSYCHOLOGY 473, 478 (A. Goldberg ed. 1980).

Roth and her colleagues[221] have identified different types of homeless individuals, including street people, highly mobile/transient individuals, and residents of shelters:

> [S]helter People may be, on occasion, indistinguishable from Street People, the only difference being that shelter space was available, they overcame their aversion to seeking help, or they overcame or resolved a personal problem sufficient enough to be admitted. Resource People, by contrast, seem very different from either Street or Shelter People, because of their support network of friends or relatives, along with some personal resources. Even though they have some resources, they are truly homeless and may have been or may become Street or Shelter People.[222]

Predictably, street people were the most socially disconnected of the three groups: they had the poorest work histories, used fewer social services, made fewer social contacts, and were more behaviorally dysfunctional.[223]

"Resource people," the homeless who lived in transient settings or with family or friends, appeared to be less socially disconnected than the other two types of homeless people. They were younger, had fewer divorces, consisted of a larger percentage of women, and had less involvement with the law.[224] This group was also homeless for the shortest period of time, its members had worked more recently, had used social services more often, had maintained more social contacts, had used alcohol less, had fewer psychiatric hospitalizations, and presented fewer health problems.[225]

Homelessness among the mentally ill should not be regarded as invariant, but rather be considered a point of accommodation in an adaptive process directed toward struggling with social and personal distress. Most chronic psychiatric patients

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221. D. ROTH, *supra* note 165, at 75.

222. *Id.* at 76.

223. *Id.* at 83-96, 124-25.

224. *Id.* at 78.

225. *Id.* at 80-96. These findings were generally consistent with the results of an intensive survey of 553 homeless individuals in England. *See* Drake, *supra* note 186, at 32-33, 47-48. The authors observe, "for most people rough sleeping was the end of 'slippery slope,' when their problems were so great that they could not even find a roof." *Id.* at 66.

are not likely to cope with homeless conditions for prolonged periods of time.[226] Although they are highly mobile and transient, many probably drift in and out of homelessness or are only temporarily homeless for brief periods, and only a small percentage are undomiciled on all admissions.[227] In one follow-up investigation of mentally ill shelter residents, only 8 out of 193 individuals repeated in both samples.[228] Even more general surveys do not yield compelling evidence which confirms a large and enduring homeless population.[229]

By and large the homeless mentally ill constitute a heterogeneous group of chronic mental patients. There is considerable overlapping between "urban nomads" and a number of different groups referred to as "psychiatric hoboes,"[230] "space cases,"[231] "forfeited patients,"[232] "treatment resisters,"[233] and "young adult chronic patients."[234] These groups manifest some common features of a larger population identified by Bachrach as "system misfits," that is, chronic mental patients who are alienated from and unresponsive to traditional forms of services.[235]

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226. A study of a shelter in Boston did find that two-thirds of a group of mentally ill homeless (about 33% with psychiatric histories) were shelter residents regularly for over six months and that 20% lived continuously on the streets and in shelters for more than two years. Bassuk, *Addressing the Needs of the Homeless*, Boston Globe, Nov. 6, 1983 (Magazine), at 60. In a Philadelphia shelter, 43% of a sample of residents were considered to be "street people" (homeless for a month or more). Arce, *supra* note 176, at 814. One year later, in a comparable sample, only 10% were identified as "chronically homeless." Vergare, Arce, Spivack & Kasiarz, Mental Illness in the Homeless: Two-year Comparison (paper presented at Annual Meeting of the American Psychiatric Association II, Los Angeles, May 1984) [hereinafter Vergare].

227. Appleby & Desai, *supra* note 183, at 9; Goldfinger & Chafetz, *Developing a Better Service Delivery System for the Homeless Mentally Ill*, in THE HOMELESS MENTALLY ILL, *supra* note 131, at 91, 94.

228. Vergare, *supra* note 226, at 11.

229. *See, e.g.*, D. ROTH, *supra* note 165, at 56; PHOENIX SOUTH, *supra* note 176, at 69; Drake, *supra* note 186, at 62 (found only 10% of the sample in England to be long-term "street people"). There are exceptions, however, *see supra* note 163 and *supra* note 226.

230. Lamb, *Board-and-Care Home Wanderers*, 37 ARCHIVES GEN. PSYCHIATRY 135, 137 (1980).

231. Segal & Baumohl, *Engaging the Disengaged: Proposals on Madness and Vagrancy*, 25 SOCIAL WORK 358 (1980).

232. Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. ORTHOPSYCHIATRY 65, 67 (1980).

233. Goldfinger, Hopkin, & Surber, *supra* note 157, at 17.

234. Pepper, Kirshner & Ruglewicz, *supra* note 154, at 17.

235. Bachrach, *The Homeless Mentally Ill and Mental Health Services: An Analytical Review of the Literature*, in THE HOMELESS MENTALLY ILL, *supra* note 131, at 11, 29.

The definition of homelessness must be broadened to embrace residentially unstable or unsettled persons. As one writer concludes, "[i]t is doubtful that the nomadic life style of many chronic patients is good for them. Episodes of homelessness are more likely to occur among patients whose living arrangements are unstable."[236] Highly mobile patients are not uncommon among the severely mentally ill.[237] They are psychiatrically less responsive than those more residentially stable;[238] though not quite as extreme, their demographic, clinical, and psychiatric patterns are generally similar to those chronic psychiatric patients without a current address.[239]

V. INTERVENTIONS

Despite the growing concern over hunger and homelessness, the chronically mentally ill and deinstitutionalization, social policies have not emerged. A task force of the American Psychiatric Association has produced a series of recommendations regarding the homeless mentally ill.[240] These have not yet been acted upon. Nevertheless, an accumulating body of research has evidenced some responsiveness to such concerns, suggesting avenues for reducing the prevalence of homelessness among the mentally ill.

In a classic paper analyzing the organizational functions of mental hospitals, Talcott Parsons,[241] a noted sociologist, indicated that custody and protection were traditionally two components of the institution's goal. There have been no concerted efforts to establish or substitute alternate types of "asylum" or social control to replace these primary functions of public hospitalization. Writers have recently raised questions about the lack

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236. Caton & Goldstein, *Housing Change of Chronic Schizophrenic Patients: A Consequence of the Revolving Door*, 29 SOC. SCI. & MED. 759, 763 (1984).

237. *Id.* at 760; Appleby, Slagg, & Desai, *supra* note 145, at 257; Segal & Baumohl, *supra* note 231, at 359.

238. Caton & Goldstein, *supra* note 236, at 761; Witheridge, Dincin & Appleby, *The Bridge: An Assertive Home-Visiting Program for the Most Frequent-Psychiatric Recidivists* 57 (Final Report to NIMH, Thresholds (Chicago, Ill., July 1982)).

239. *See* Chafetz & Goldfinger, *supra* note 181, at 25-26; Appleby, Slagg & Desai, *supra* note 145, at 259.

240. *See* THE HOMELESS MENTALLY ILL, *supra* note 131, at 1-10, and *supra* note 158.

241. Parsons, *The Mental Hospital as a Type of Organization*, in THE PATIENT AND THE MENTAL HOSPITAL 108, 110 (M. Greenblatt, D. Levinson, & R. Williams eds. 1957).

of asylum or sanctuary resulting from deinstitutionalization, and have urged its re-introduction as one means of correcting an imbalance in the network of mental health services.[242] Bachrach suggests that planning major system changes necessitates substitution and observes that "[o]ne of the service interventions for which a functional equivalent is essential for any system of care is that of asylum. A responsive service system simply must provide for the safety and security of those patients who need protection."[243] In addition to the need for prolonged care, asylum—wherever it is offered—must be more readily accessible to the chronic mentally ill. It must provide them an opportunity to enhance their attachment potential and personal stability.

Increased attention concerning the absence of custody and protection is a reaction to higher admission rates, the revolving-door phenomenon, and increasing homeless and disaffiliated mentally ill persons—in brief, large numbers of unsettled people in the community. Society's lack of readiness to accept the burden of deinstitutionalization is vividly represented in a newspaper article which appeared several years ago in the New York Times:

> Under a tightened admission policy, thousands of ill people who would have been accepted a few years ago into New York State psychiatric hospitals are being turned away, and they are packing New York City's hospitals beyond capacity.
>
> New York State says it has ceased its older policy of "deinstitutionalization". . . . But newly ill people are being admitted only if their symptoms are obviously severe.
>
> . . .We do not admit elderly people with organic brain syndrome; we do not admit people who are maybe a little bit strange and don't have a place to live. We are not a shelter, the city has not yet confronted the issues.
>
> Mayor Koch has asked the state to continue to provide long-term care to the mentally ill. "The state policy of releasing deinstitutionalized patients without adequate

242. *See, e.g.*, Appleby, *supra* note 156, at 12; Bachrach, *supra* note 156; Thomas, *On The Need For Asylums*, DISCOVER, Dec. 1981, at 68, 71; Talbott, *The Need for Asylum, Not Asylums* (Commentary) 35 HOSP. & COMMUNITY PSYCHIATRY 209 (1984).

243. Bachrach, *supra* note 156, at 977.

> support has turned the city neighborhoods into mental wards and the police into hospital orderlies. . . .What is needed is a coherent state program which would include long-term care facilities, community-based support facilities and appropriate institutional care for the chronically mentally ill."
>
> . . . We are rationing mental health care. Our average length of stay is 10 days which is just about getting them stabilized.[244]

Unfortunately, unanticipated consequences are often the result of social change. There are indications that more restrictive admissions criteria have led to increased criminalization of the mentally ill;[245] the obvious implication is that by default, the criminal justice system has emerged as an "alternative system of social control."[246] In California, for example, a year after the new mental health code was adopted, there was a 100% increase in the number of arrests followed by incompetency pleas.[247] The growth in prison and, especially, jail populations may be partially a function of increased admissions of former mental patients: "These findings suggest that the jail. . .may have become a 'revolving door' for the chronically mentally ill person."[248] The results are even more significant for the homeless mentally ill since they have considerably more contact with the criminal justice system than other mental patients.[249] Homeless people in general, however, seem to have difficulty with the law. Several surveys indicated that fifty to sixty percent of those interviewed had been in jail or prison.[250]

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244. Herman, *supra* note 159, at 16-17.

245. *See, e.g.*, Whitmer, *supra* note 232, at 65; Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AM. PSYCHOLOGIST 794, 800 (1984); Feigenbaum, *The Criminalization of the Mentally Ill*, 40 AM. PSYCHOLOGIST 1063 (1985); Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899, 905 (1984).

246. Teplin, *supra* note 246, at 802.

247. Whitmer, *supra* note 232, at 66.

248. Teplin, *supra* note 245, at 801.

249. *See, e.g.*, Lipton, Sabatini & Katz, *supra* note 175, at 819; Appleby & Desai, *supra* note 154, at 736, 737; Goldfinger, Hopkin & Surber, *supra* note 157, at 19; Bassuk, Rubin & Lauriat, *Is Homelessness a Mental Health Problem?*, 141 AM. J. PSYCHIATRY 1546, 1548 (1984); Lamb, *supra* note 245, at 905.

250. *Men Who Use the New York City Shelters*, *supra* note 163, at 25; PHOENIX SOUTH, *supra* note 176, at 32; D. ROTH, *supra* note 165, at 33.

Shelters and missions are increasingly replacing mental hospitals as the institutional source of custodial and sanctuary functions. The number of shelter beds has risen rapidly in the past several years.[251] Previously these beds provided emergency assistance. Now, however, they frequently serve as a continual source of shelter for selected homeless people, including former mental patients.[252] Shelters or missions are a principal housing source for recently discharged patients and are often a "retreat" for individuals who have been refused hospitalization. Though shelters were universally designed as a response to poverty and economic need, they are slowly evolving into facilities for the social control of deviance and as alternatives to psychiatric hospitalization.[253] Like jails, shelters are not equipped to address the multifaceted problems of chronically mentally ill individuals.[254] Furthermore, shelters reinforce for the homeless mentally ill a sense of their isolation and social disconnectedness, while also reminding them of their underclass status.[255] As Bassuk notes "[t]he shelters have become 'open asylums' to replace the institutions of several decades ago . . . . However, without provision of a sophisticated combination of services that accounts for the special characteristics of this population . . . the plight of the homeless mentally ill will continue to be desperate."[256]

A variety of programmatic efforts are taking place both within and outside the mental health service field. Perhaps most important is the movement in a number of communities around the country not only to stop the loss of SRO housing but also to obtain funds for its rehabilitation and continued use for low-in-

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251. HUD, *The Homeless and Emergency Shelters*, *supra* note 160, at 34.

252. Bassuk, Rubin & Lauriat, *supra* note 249, at 1549.

253. *See, e.g., id.*

254. Many chronically mentally ill are ill-equipped to manage their daily lives in an independent and productive manner. Day-to-day shelter is simply insufficient! They need refuge from stress in supportive and supervised living arrangements, access to basic elements of survival (food, clothing, medicine), and social mental health services to help them cope with problems in living (advocacy, case management, skill training, counseling, etc.). Appleby, Slagg & Desai, *supra* note 145, at 259. *Cf.* Bassuk, *supra* note 176, at 45; Talbott, *supra* note 144, at 45; Peterson, *What are the Needs of Chronic Mental Patients*, in THE CHRONIC MENTAL PATIENT, at 39-49 (J. Talbott ed. 1978). For a comprehensive listing of needs see Levine, *Service Programs for the Homeless Mentally Ill* in THE HOMELESS MENTALLY ILL, *supra* note 131, at 173, 197-98.

255. Mowbray, *supra* note 1, at 4-5.

256. Bassuk, Rubin & Lauriat, *supra* note 249, at 1549.

come persons.[257] A national conference was held in Los Angeles in April, 1985 to explore issues involved in restoring SRO housing. There are reports of current preservation projects in Portland, Los Angeles, and New York, as well as in other cities.[258] An eighteen-month moratorium on demolition of SRO housing is in effect in New York City, which has also pooled funds with the state to rehabilitate city-owned buildings;[259] in Illinois, $5,000,000 has been allotted to the Illinois Housing Development Authority for the rehabilitation of single-room occupancy hotels.[260]

The homeless mentally ill are part of a larger, highly transient psychiatric population which is frequently unreachable and reluctant to use mental health outpatient and other social services. Though often viewed as public nuisances, they are extremely vulnerable persons, typically experiencing marked difficulty in coping with daily living and repeatedly requiring psychiatric hospitalization.[261] Their need for care persists despite their reluctance to accept traditional programs. This group of chronically mentally ill require an alternative system of mental health care which is inviting, flexible, low key, and which is capable of meeting their needs.[262] Shelters, missions, and social detoxification centers have proven to be among the most effective services attracting homeless people.[263] In addition to being accepting, relatively undemanding, and highly supportive, these settings concretely attend to survival requirements.[264] In this respect, the undomiciled mentally ill are like other homeless individuals; they perceive housing, money, jobs, food, and social

257. Saffrin & Goldberg, *supra* note 207, at 1, 12-14.

258. *Id.*

259. *Id.* at 13.

260. *Id.*

261. Appleby, Slagg & Desai, *supra* note 145, at 258.

262. *Id.* For more detailed analyses of the properties of a service system for the homeless *see* Bachrach, *supra* note 235, at 36-44; Goldfinger & Chafetz, *supra* note 227, at 97-106.

263. *Id.* Some refer to these as "contact services." Lipton & Sabatini, *Constructing Support Systems for Homeless Chronic Patients*, in THE HOMELESS MENTALLY ILL, *supra* note 131, at 153, 160.

264. Appleby, Slagg & Desai, *supra* note 145, at 258. *See also* Levine, *supra* note 254, at 174-77; Lipton & Sabatini, *supra* note 263, at 157, 160-61. For a position which largely focuses on the basic survival and living needs of the homeless see Baxter & Hopper, *supra* note 207, at 109-39.

contacts as their predominant problems and needs.[265]

The relatively successful mental health programs for the homeless mentally ill are responsive to these needs. These programs include case management/outreach services, drop-in centers, and transitional and long-term housing arrangements.[266] The first two are essentially "contact services" to ease access to the system.[267] Case management functions must be performed in a non-demanding and low-expectancy manner, and aggressively reach out to chronic patients in their natural habitat, providing the means with which to obtain survival needs.[268] In New York City, for example, Project Help[269] is a mobile outreach service largely for the lower East Side of Manhattan. A team operating out of a van cruises the streets or takes telephone referrals to assist impaired homeless people with crisis medical and psychiatric care. Approximately eighty percent of their cases are believed to have a psychiatric disorder.[270] Drop-in centers offer daytime retreats for former psychiatric patients: a place to get a meal, protection from the weather, medical aids, social services, and assistance with needs for shelter.[271] A center operated by the Missouri Department of Mental Health, located near downtown St. Louis, principally attracts transient, formerly hospitalized patients.[272]

Obviously, the primary need not only for the homeless but for the chronically mentally ill as a whole, is a wide array of supportive living arrangements. Severe mental illness is a lifetime disorder. Many afflicted with this condition will be able to

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265. *See* Ball & Havassy, *A Survey of the Problems and Needs of Homeless Consumers of Acute Psychiatric Services*, 35 HOSP. & COMMUNITY PSYCHIATRY 917, 919-20 (1984); D. ROTH, *supra* note 165, at 139; Stevens, *supra* note 177, at 35.

266. For a description of the specific mental health support services and programs needed by the homeless *see* Lipton & Sabatini, *supra* note 263, at 153, 157-71; Shiffren-Levine, *Service Programs for the Homeless Mentally Ill* in THE HOMELESS MENTALLY ILL, *supra* note 131, at 173-200.

267. *See* Lipton & Sabatini, *supra* note 263, at 159.

268. *See, e.g.*, Withridge, Dincin & Appleby, *Working With The Most Frequent Recidivists: A Total Team Approach to Assertive Resource Coordination*, 5 PSYCHOSOCIAL REHABILITATION J. 9-11 (1982).

269. Cohen, Putnam & Sullivan, *The Mentally Ill Hoomeless: Isolation And Adaptation*, 35 HOSP. & COMMUNITY PSYCHIATRY 922-24 (1984).

270. *Id.* at 923.

271. Levine, *supra* note 254, at 186-89.

272. M. ROEBUCK, THE HOMELESS, PROGRESS NOTES, Spring 3-6 (Mo. Dep't of Mental Health, Springfield 1984).

cope only marginally with the usual stresses of daily life and may require new social networks as well as a place to reside. At this point most of the housing opportunities for the homeless mentally ill are emergency shelters.[273] In rare instances, transitional housing programs will accommodate individuals for periods of up to one year.[274] These sites, however, have neither the staff nor time to deliver other services.[275] In contrast, a long-term housing program is based at the St. Francis Residence, a former SRO, in New York City.[276] It provides social-rehabilitation activities to chronic psychiatric patients, including some street people, under an inter-agency cooperative agreement. The St. Francis Program developed from an earlier crisis-support system in another hotel for recently discharged mental patients.[277]

Thus far we have been reviewing and discussing the kinds of efforts that are currently employed to alleviate or reduce the problem of homelessness among the mentally ill. Once the point of alienation or disaffiliation has been reached there is little choice other than palliative measures. The critical question is whether the process of social disconnectedness can be arrested at an earlier stage in order to establish a social network for the severely mentally ill. Relapses are less likely for chronic psychiatric patients who maintain a bond even with a limited support system.[278] For the past 10 years a number of researchers have

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273. It should be understood that these beds are available only for the night and that the guests must vacate by early morning, navigate for themselves during the day, and reapply for shelter again the next night. In England, individuals may have been "stable" residents in a setting for many years but only a small percent could be considered to be in legally secure accommodations. *See* Drake, *supra* note 186, at 53-54. In Dublin, while some residents may have lived in the same hostel for twenty years or even be paying a token fee, "all (hostels) require residents to depart the premise each morning after breakfast and. . .'book in' each evening." Kearns, *supra* note 173, at 226.

274. *See, e.g.*, Levine, *supra* note 254, at 191-92. describing the House of Ruth in Washington, D.C.

275. *Id.* at 175-76, 192. A number of private efforts are involved in offering support services. For example, about $25,000,000 is being provided by the Robert Wood Johnson Foundation and the Pew Memorial Trust for health care grants in eighteen U.S. cities. Shwartz, *Liability Fears Hamper Care for the Homeless* AM. MEDICAL NEWS, Dec. 27, 1985, at 3.

276. Levine, *supra* note 254, at 193-95.

277. Cohen, Sichel & Berger, *The Use of Mid-Manhattan Hotel as a Support System*, 13 COMMUNITY MENTAL HEALTH J. 76-83 (1977).

278. Cohen & Sokolovsky, *Schizophrenia and Social Networks: Ex-Patients in the*

used family therapy/family management as a means of reducing relapse rates in schizophrenic patients.[279] Both the original English study and a later replication of it indicated that patients who lived in a highly stressful family environment were more likely to relapse than those who lived in a more emotionally neutral situation.[280] Taking medication or reducing the amount of direct contact with emotionally involved families also helped the patient cope more effectively.[281] This research has been repeated in this country and the authors conclude that "a high degree of criticism or OEI (over emotional involvement) expressed by the relative is the best single prediction of the return or exacerbation of. . .schizophrenic symptomatology. . .following discharge."[282] Related studies measuring the impact of working with families revealed fewer readmissions, fewer symptoms and more social improvement 24 months after discharge.[283] Treated families experienced less distress and fewer social burdens, and were better able to handle the situation.[284]

Evidence indicates two major reasons for the high relapse rate in the severely mentally ill are noncompliance with treatment and stressful environments.[285] Engagement with families successfully demonstrates the utility of family management in reducing post-hospital stress for schizophrenic patients.[286] This approach does not focus on causes, but is based on the notion that schizophrenic persons are vulnerable to stimulating envi-

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Inner City, 4 SCHIZOPHRENIA BULL. 546, 557 (1978); Goldstein & Caton, *The Effects of the Community Environment on Chronic Psychiatric Patients*, 13 PSYCHOLOGICAL MED. 193, 196-98 (1983).

279. Vaughn & Leff, *The Influence of Family and Social Factors on the Course of Psychiatric Illness*, 129 BRIT. J. PSYCHIATRY 125, 129 (1976).

280. *Id.* at 128-29.

281. *Id.* at 130.

282. Vaughn, Snyder, Jones, Freeman & Falloon, *Family Factors in Schizophrenic Relapse: Replication in California of British Research on Expressed Emotion*, 41 ARCHIVES GEN. PSYCHIATRY 1169, 1176 (1984) [hereinafter Vaughn].

283. I. FALLOON, J. BOYD & C. MCGILL, FAMILY CARE OF SCHIZOPHRENIA: A PROBLEM-SOLVING APPROACH TO THE TREATMENT OF MENTAL ILLNESS 35 (1984).

284. Falloon & Pederson, *Family Management in the Prevention of Morbidity of Schizophrenia: The Adjustment of the Family Unit*, 147 BRIT. J. PSYCHIATRY 156, 160 (1985).

285. Anderson, Hogarty & Reiss, *The Psycho-educational Family Treatment of Schizophrenia*, in NEW DEVELOPMENTS IN INTERVENTIONS WITH FAMILIES OF SCHIZOPHRENICS 79 (M. Goldstein ed. 1981) [hereinafter Anderson].

286. Falloon, Boyd & McGill, *supra* note 283, at 351-52, 396.

ronments due to psychophysiological deficiencies.[287] By educating the family, therapists can decrease anxiety levels and enhance family skills in managing the illness. Such efforts can reduce overstimulation and moderate the emotional climate.[288] Consistent with this theory, some writers have concluded "[i]t is not surprising that if these patients encounter stimulating environments in the home or the workplace or even in treatment settings, relapse rates increase."[289]

From the perspective of preventing homelessness, we think that application of family management procedures early in the career of chronic patients offers a distinct possibility of reducing environmental stress and increasing the prospects for residential stability. Efforts which can at least forestall, if not mitigate, the process of social disconnectedness should markedly affect the potential incidence of homelessness.[290] Goldman, from a slightly different vantage point, has recommended a comprehensive public health model to address the comparatively large numbers of chronically mentally ill living with their families.[291] His program features therapy, home visiting, support groups, and respite care.

Estimates of chronically mentally ill who actually reside with their families vary considerably.[292] Highly recidivistic individuals are likely to live on their own and have less contact with relatives.[293] Family interventions are not especially feasible in these instances but there are indications that, even in non-famil-

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287. They are equally vulnerable to non-stimulating settings. The authors state that "active, intense, and overstimulating inpatient treatment programs have been shown to produce positive signs of schizophrenia as have ambitious attempts at rehabilitation. Conversely, understimulating therapeutic settings appear to contribute to negative symptoms, such as amotivation, withdrawal, apathy, and blunted affect." Anderson, Hogarty & Reiss, *Family Treatment of Adult Schizophrenia Patients: A Psycho-Educational Approach*, 6 SCHIZOPHRENIA BULL. 479, 480 (1980).

288. Anderson, *supra* note 285, at 81.

289. *Id.* at 80.

290. Our view is that homelessness for the mentally ill is the end point of a series of disruptive life situations which culminate in extreme forms of social disaffiliation. If tension and stress can be reduced within key social networks, then social connectedness may be prolonged! *Cf.* Bassuk, *supra* note 176, at 43, for similar thoughts on homelessness.

291. Goldman, *supra* note 214, at 557-59.

292. *Id.* at 558. Talbott reports that only 23% of chronic mental patients currently return to their own homes after discharge. Talbott, *Toward a Public Policy*, *supra* note 144, at 45.

293. Caton & Goldstein, *supra* note 236, at 760; Vaughn, *supra* note 282, at 1171.

ial settings, chronic psychiatric patients are at a higher risk for readmission if living in stressful and unsupportive environments.[294] We may infer from these findings that there are common properties in familial or non-familial settings which may be either more or less "therapeutic." Those measures enhancing family support systems and coping ability may be similarly employed to design networks of human environments for less socially connected psychiatric patients.

VI. CONCLUSION

Historians and philosophers will have an interesting time in describing our era of deinstitutionalization. Madness is no longer linked to classical man's striving for rationality and the rigid social order of the nineteenth century. It is no longer hidden, but free from institutional captivity, a condition made public under libertarian values and changing laws. The focus has shifted from curing mental illness to its control.[295] Madness without walls has

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294. Cohen & Sokolovsky, *supra* note 278, at 557-58; Goldstein & Caton, *supra* note 278, at 198.

295. The notion that insanity could be *cured* was a prevalent idea in colonial and pre-Civil War times and was an intrinsic aspect of the idealogical basis of "moral treatment." G. GROB, *supra* note 4, at 42-46; D. ROTHMAN, *supra* note 4, at 131-33. Although "recovery from illness" was still referred to in post-World War II developments (*see, e.g.*, Parsons, *supra* note 241, at 111), the move from custodial to therapeutic institutions largely emphasized concepts of social adjustment and interpersonal behavior and especially the use of the social environment in goals of *rehabilitation*. *See, e.g.*, M. JONES, *supra* note 61, at XV-XXI; Greenblatt, *supra* note 69, at 5-18.

There is increasing recognition since the era of deinstitutionalization and the advent of the community mental health movement that severe mental illness is a lifetime disorder (*see, e.g.*, Hansell, *Services for Schizophrenia: A Lifelong Approach to Treatment*, 29 HOSP. & COMMUNITY PSYCHIATRY 105-09 (1978) and that chronic psychiatric patients are typically very disabled individuals with limited personal resources. *See, e.g.*, Bachrach, *supra* note 156, at 976; Talbott, *Toward a Public Policy*, *supra* note 144, at 45. In a major conference, the more significant characteristics attributed to the chronic mental patient by the participants included "high vulnerability to stress, difficulties in securing adequate income, and problems holding down a job. These are people whose emotional disabilities are so serious and persistent that without availability of a special support system they would be unable to make a stable adjustment to community life." Working papers from the Conference on the Chronic Mental Patient (Appendix D) in THE CHRONIC MENTAL PATIENT, *supra* note 97, at 231. Despite their reference as "psychosocial rehabilitation services," the thrust of the extensive range of recommended community support programs is essentially directed toward *controlling* mental illness by stabilizing and maintaining the chronic psychiatric patient in the community. For example, a policy statement emerging from the conference described above states that "[t]he system (of services) should recognize that some patients, while chronically disabled, are only par-

led to a degradation of man different not in degree, but only in kind from that of confinement. Despair, alienation, and disaffiliation persist.

Homelessness among the mentally ill is a pervasive phenomenon not indigenous only to the United States. Like all social undesirables under the poor laws of the sixteenth and seventeenth centuries, homeless persons, unfortunately, are being linked together, and the problems peculiar to chronic mental disability diluted. Addressing it solely as a poverty issue is insufficient! The response to the homeless mentally ill must come from a variety of levels. Why some chronically mentally ill become homeless and others do not must be studied. We must continue to look for clues. We must search for ways to develop environments—including asylums—which will enable chronic psychiatric patients to become more settled, to enhance their capacities for growth, and to improve the quality of their lives within the limitations of their disability. Our energies should be ultimately invested in programs aimed at the prevention of homelessness among the severely mentally ill and not in policies which repeatedly result from crisis reactions.

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tially disabled and can function in supportive situations. The system should be designed to promote growth and sustain functioning to the maximum degree feasible for each individual." Policy Statement in THE CHRONIC MENTAL PATIENT, *supra* note 97, at 211. *See* Turner, *Philosophical Issues in Meeting the Needs of People Disabled by Mental Health Problems; The Psychosocial Rehabilitation Approach* in THE CHRONIC MENTAL PATIENT, *supra* note 97, at 65-72, for views on psychosocial rehabilitation programs. *See also* Talbott, *Toward a Public Policy, supra* note 144, at 45-46, for some discussion of support services and their effectiveness.