

Profile of Care
Treatment of Persons with Mental Illness
History, Consequence and Funding Issues

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for the

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Kane County, Illinois

January 15, 2007

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A Brief History

In ancient times, the care of persons with mental illness was addressed in various ways. Archaeology has shown us that shamans used exorcism or drilled holes in the heads of persons displaying mental illness to encourage the evil spirit to leave the suffering person. The early Egyptians focused on the soul and the healing of the soul by discovering the source of the illness. They used opium to induce visions, dream analysis, and prayers to specific gods to heal the suffering soul. The early Hebrews equated spiritual health with mental health and mental illness as the result of a poor relationship with God. Mental illness in the middle ages was very often diagnosed as witchcraft, and those convicted of witchcraft were often tortured and killed.

In the American colonies, the first legal code of 1641 contained several references to distracted persons and idiots in regards to the care of their goods. By 1694 a Massachusetts statute had made all insane persons without families the legal responsibility of the community. Although, specific therapies for persons with mental illness were rarely mentioned before the 1800s, bleeding and purging were most common as the distinction between the medical and mental diseases was vague at best. Mental disorders were mostly thought to flow from both natural as well as supernatural forces. (Grob, 1994)

In the early United States, the care of the person with mental illness often required some kind of public intervention. The largely rural nature of the country in the 18th century entrusted the individual with mental illness to the care of individual towns and villages to provide various supports to help families who had a relative who had a mental illness. As populations increased, the informal manner of towns caring for such persons became inadequate, and larger towns began to create almshouses. It was in Philadelphia in the mid-eighteenth century that the first hospital was founded to provide treatment for those who were deemed to be “Lunatics or Persons distemper’d in Mind, and deprived of their rational Faculties...” (Grob, p. 19). Founded in 1752, by 1787, only 34 of the persons admitted were classified as insane.

In the 19th century the ideas of the Enlightenment had spread to the United States, bringing the secular ideals that problems could be overcome by conscious and purposeful human intervention. In addition, a religious revival movement called the Second Great Awakening affected the Christian institutions. There was a growing faith that human institutions could be improved and individuals could be perfected. Dorothea Dix argued valiantly for care of the insane—to take them out of jails and almshouses and to treat them in asylums where they could receive care. The attitudes towards insanity itself also underwent changes. Therapy to retrain the insane was considered possible, assisting them to develop internal means of self-restraint and self-control. These ideas of reform were aided by increased financial support of wealthy elites in urban communities as well as a growing consensus that government had an obligation to foster the welfare of its citizens. (Grob, 1994).

Financial problems were an issue in the early hospitals in spite of the fact that they also had some successes. It was unsure just how the support for patients who could not pay would be handled. By the 1820s, it was becoming clear that the idea that asylums that could serve all members of society would not work. The immigration of large numbers of minority groups, an increase in unemployment, poverty, indigency, disease and crime also increased class distinctions. Private hospitals for persons with mental illness grew but became exclusive, not only because of the financial situation, but also because families did not want their family members in the hospital to mix with ethnic and racial minorities they deemed undesirable. In cities across the country, state mental hospitals were set up as well as private and corporate asylums for those who did not want to use the public institutions. (Grob, 1984).

The positive view of the state asylums to ameliorate mental illness began to change at the beginning of the 20th century. Admission to mental institutions was done largely at the behest of families. The popular conception was that persons could be cured in these institutions, and the bulk of patients remained in the hospital for less than a year. Yet, there was an increasing number of persons deemed to have chronic mental illness and were remaining in the mental institutions indefinitely. There was a shift in the fundamental character of these institutions towards custodial care rather than therapeutic care. The concept of the efficacy of modern medicine and science to effect cures was greatly diminished. The positive views of these institutions that had been there at the beginning gave way to a view of them as associated with hopelessness and death. (Grob, 1984)

During the 20th century, significant occurrences began to effect changes in the way persons with mental illnesses were treated.

The National Committee for Mental Hygiene was formed in 1909 with the intention of reforming the mental hospitals. However, by 1917, this original intention was completely changed. Advances in the prevention of diseases as well as the ideas of Freud had begun to permeate the medical community. The idea became promulgated that intervention could prevent mental illness before it began. Psychiatric services no longer needed to be confined to mental institutions. Not only was work in the mental institutions perceived as dead-end jobs with little esteem, but it was determined that it was important that psychiatrists should now be involved with the behavior of persons in their everyday lives in order to prevent faulty development. New radical somatic therapies were also introduced. These included fever therapy, insulin, Metrazol and electric shock therapy and lobotomy. There was however, little scientific basis for most of these somatic therapies, and their administration was given following vague diagnoses and with mostly inadequate controls. (Grob, 1984; Torrey, 1988).

During World War II, mass screenings were conducted to keep those unfit for combat out of the military. Yet, there was a high degree of neuropsychiatric breakdowns among military personnel—this after the supposedly unfit had been weeded out. It seemed to follow that stress must be a major factor in causing mental illness. If this were the case, then it also followed that intelligent planning in the form of psychotherapy could alleviate stress and accompanying neurotic symptoms. This treatment would best be administered close to the source of the stress, and should not necessitate removal to an institution. It

followed then that community care would be more beneficial for alleviating symptoms of psychological distress than the removal to institutional care. (Grob, 1984)

Published books and articles brought increasing scrutiny in upon institutions

serving persons with mental illness occurred in the mid-twentieth century. The *Shame of the States*, written by Albert Deutsch and published in 1948, portrayed the overcrowding and understaffing in the institutions. They revealed tragedy and degradation, not the result of the hospital staffs, but the fact that there was not enough money to support a full staff, including doctors, equipment, facilities, and services. Albert Q. Maisel published a lengthy piece in 1946 in *Life* called *Bedlam*. His texts and photographs compared mental hospitals with Nazi concentration camps. Also in 1946, Mike Gorman wrote a series of articles chronicling the sad state of affairs at Oklahoma's state hospitals. A novel, *The Snake Pit*, by Mary Jane Ward, published in 1946, condensed in *Reader's Digest*, and made into a motion picture, showed severe institutional defects but faith in the power of psychodynamic and psychoanalytic psychiatry. She blamed inadequate governmental support. (Grob, 1984).

The National Institute of Mental Health (NIMH) was signed into law On July 3, 1946 by President Truman with the intention of improving the treatment of persons with serious mental illness in state hospitals as well as the prevention of mental diseases. It was charged with three activities: research, training and service assistance to the states. The significance of this act was more that it provided a vision for the future and had general goals than it had specific provisions. Although NIMH was committed to the development of new and innovative community programs, little attention was paid to program evaluation. Guidelines and information about the kind of training required for community health programs were almost non-existent. It wasn't until 1948 that funds were made available. (Grob, 1984; Torrey, 1988)

The American Psychiatric Association in 1953 called for a national commission to study current conditions of mental health services and to develop a national mental health program instead of the stopgap programs that were currently in place. It was reported that 75% of all patients in mental health hospitals had been there two years or more. It was estimated that the budget for state mental hospitals was requiring 35% of a state's budget and that there were far too few psychiatrists to treat these patients. A joint commission was authorized to evaluate the needs of persons with mental illness and to make recommendations. During this time the NIMH had obtained great increases in federal funding: from \$6.5 million to \$41 million for research and from \$4.5 million to \$42.5 million for training, but only from \$4.2 million to \$7.7 million for services. Though the report was completed towards the end of the Eisenhower administration, it was decided to hold it until two months after Kennedy was elected, as it was thought a Democratic administration would look at it more favorably. (Torrey, 1988)

New anti-psychotic drugs were found to be very effective in treating some of the symptoms of psychosis, especially schizophrenia, at the same time that the Joint Commission was preparing its study and while the NIMH was increasing its budget. Although this great improvement in the effectiveness of these drugs was not related to either event, it had a great influence on both. The population of the mental hospitals was decreasing for the first time in almost two hundred years. This gave additional impetus to

the viability that patients may be able to be treated effectively outside the confines of the mental institution. (Torrey, 1984).

The Action for Mental Health report was published as a result of the study, even though the study had specified mental *illness* as well as mental *health*. Although it contained some insightful analysis, its recommendations did not often align with the analysis. The state mental hospitals were placed in a secondary role to community mental health clinics. The idea was that there would be one such clinic for every 50,000 people in the country. These clinics were to concentrate on those with acute mental illness and for patients who could be helped instead of being admitted to hospital or following hospital discharge. There was also emphasis on aftercare and rehabilitation for persons with mental illness after hospital discharge and utilizing psychiatric units within general hospitals and psychiatric treatment centers. It also stated that since the states did not have the financial resources to provide such services, the federal government should shoulder the financial burden. Other parts of the report also suggested that counseling services should be a part of these clinics. (Torrey, 1988).

Mental health was officially defined by the commission:

- 1) the attitudes of the individual towards himself.
- 2) the degree to which the individual realizes his potentialities through action.
- 3) unification of function in the individual's personality
- 4) the individual's degree of independence of social influences
- 5) how the individual sees the surrounding world.
- 6) The individual's ability to take life as it comes and master it. (Torrey, 1988, p. 94-95)

The beginning of the community mental health centers (CMHC) was to be a profound change in the treatment of persons with mental illness. No longer would state mental hospitals be the main treatment centers but treatment would be shifted to CMHCs. During the Senate hearings in 1963 regarding the proposed CHMCs, state hospitals were characterized as merely quarantining persons with mental illness, not treating them. It was deemed that these custodial hospitals were unsuitable to treat mental illness. The creation of the CMHCs was to be a bold new approach—to treat persons with mental illness in their home communities. Although there had been no research, no pilot programs, no evidence that admissions to state hospitals would be decreased, the community mental health legislation passed Congress easily and was signed into law on October 31, 1963. (Torrey, 1988)

Five essential services were determined as necessary to be provided by the community mental health centers:

- 1) Inpatient services
- 2) Partial hospitalization (during days only)
- 3) Outpatient services
- 4) Emergency services, available 24 hours a day
- 5) Consultation and education services

Each center would serve from between 75,000 and 200,000 population area. No provision was made for a mandatory working relationship between the centers and the state mental hospitals. (Torrey, 1988)

There were to be two directors between 1964 and 1978—Stanley Yolles followed by Betram Brown. These men, carrying on the dreams of their predecessors, set the course that the CHMCs should not only treat, but also prevent mental illness and improve the mental health of the general population. They deemed it necessary to improve the social conditions that cause mental disorders. Mental health was to be conceived as a social problem. (Torrey, 1988)

Regulations notwithstanding, there was never a clear direction regarding the nature and functioning of the centers. In addition, the centers largely served a different kind of clientele than the state mental hospitals. The promotion of mental health and prevention became the primary roles of the center. The purpose of the centers was to better people by improving their physical environment, their educational and cultural activities and social and environmental conditions. Creation and construction of these CHMCs proceeded very slowly. The first federally funded center opened in 1967. There was a significant shortage of personnel. The administration of who would ensure that persons with mental illness would have access to housing, food, support systems and jobs was not adequate. (Torrey, 1997)

The concept of mental illness began to become subsumed into the generic terminology of mental health. As this concept of mental health became expanded, it became more accepted that “almost any undesirable behavior or constellation of traits can be labeled as a disorder.” (Torrey, 1997, p. 82). The Diagnostic and Statistical Manual of Mental Disorders listed 106 mental disorders in its first manual in 1952. With the publishing of its fifth edition in 1994, over 300 disorders are listed, including such disorders as written expression, breathing-related sleep disorder and oppositional defiant disorder. Although the community mental health centers were originally intended to target the state hospital population, the reality is that the focus was on a broad spectrum of mental health problems. For the vast majority of community mental health centers, persons with severe mental illness patients comprised only 20% of the patients. (Torrey, 1997).

Summary: The goal of moving persons with mental illness from institutions to receiving support and care in CHMCs has been a laudable goal, but one that has never been achieved. Although there have been pockets of adequate and ongoing care, the statistics on persons with mental illness in this country reveal a far different story. The goals of providing diagnostic and evaluation services, outpatient services, inpatient services, day and night care, access to housing, food, support systems and jobs seldom materialized. Most of persons with mental illness persons are not in mental institutions, and the question is what has happened to them.

Consequences of Lack of Treatment

The consequences of lack of treatment for persons with mental illness are tragic.

The Treatment Advocacy Center has stated that there are about 4.5 million people in this country who have a severe mental illness, such as schizophrenia and bipolar disorder. Of this number an estimated 1.6 million are not being treated for their illness at any given time. In an effort to preserve the civil rights of the person with a mental illness, civil rights advocates have changed state laws and practices to such an extent so that it is now virtually impossible to treat such individuals unless they first commit a violent act. In addition, public psychiatric services have deteriorated significantly over the years with the closure of state psychiatric hospitals without a concomitant increase in outpatient services. The following are consequences as cited at www.psychlaws.org, the website of the Treatment Advocacy Center.

. **Homelessness**

- . People with untreated psychiatric illnesses comprise one-third, or 200,000 people, of the estimated 600,000 homeless populations.

. **Incarceration**

- . People with untreated serious brain disorders comprise approximately 16 percent of the total jail and prison inmate population, or nearly 300,000 individuals.

. **Episodes of Violence**

- . Some persons with untreated severe mental illness may become violent. Persons with severe mental illness who are taking their medication are not more dangerous than the general population. Persons with severe mental illness who are not taking their medication are more dangerous than the general population.

. **Victimization**

- . Most crimes against individuals with severe psychiatric disorders are not reported; in those instances in which they are reported officials often ignore them

. **Suicide**

- . Suicide is the number one cause of premature death among people with schizophrenia, with an estimated 10 percent to 13 percent killing themselves. Suicide is even more pervasive in individuals with bipolar disorder, with 15 percent to 17 percent taking their own lives.

. **Clinical Outcomes More Severe – Recovery Uncertain**

- . The longer individuals with serious brain disorders go untreated, the more uncertain their prospects for long-term recovery become.

Funding Issues

The shifting of services from the state institutions to CHMCs has also given rise to a labyrinth of funding issues. The costs have shifted from the state and local governments to the federal government, especially to Medicaid. “The consequences of this policy have put persons with mental illness persons onto the streets and into jails, have produced uncoordinated care and revolving-door readmissions, and have led to the transinstitutionalization of hundreds of thousands of persons with mental illness individuals from state psychiatric hospitals to nursing homes and other institutions, many of which are more restrictive and offer worse care than the hospitals from which these patients were discharged.” (Torrey, 1997, p. 91)

Medicaid, officially known as Title XIX of the Social Security Act, was enacted in 1965 by the federal government to help the state and local governments pay for acute medical care costs for low-income individuals. It is financed jointly by federal, state and sometimes local funds. States have been mandated to cover persons who receive Aid to Families with Dependent Children, Supplemental Security Income (SSI), and to cover specific medical services such as inpatient and outpatient care in general hospitals, emergency room services, nursing home care and physician care. States have the leeway to cover other optional services such as case management, rehabilitation, home health care and services by non-physicians. This has basically allowed states to receive an unlimited amount of money from the federal government as long as they were willing to contribute matching funds. Medicaid spending has increased each year. (Torrey, 1997)

In regards to persons with a mental illness, Medicaid has become the largest mental health program in the country. When a person with mental illness is in a state psychiatric hospital, the state pays most of the hospital cost. When that person is transferred to a nursing home, Medicaid pays 50-80% of the cost, depending on the state. Persons with mental illness in state psychiatric hospitals are not eligible for Medicaid unless they are under 22 or over 65. Estimates are that 15% of Medicaid monies go towards psychiatric disorders. (Torrey, 1997)

Medicare, officially known as Title XVIII of the Social Security Act, was also enacted in 1965, to cover medical costs for elderly and disabled Americans. This is entirely funded by the federal government. It is estimated that 3% of its costs go for coverage of psychiatric disorders. (Torrey, 1997)

The Supplemental Security Income (SSI) program, which provides income support for low-income elderly, blind or disabled adults and blind or disabled children, was established in 1974. Once a person is approved for SSI, he is also eligible for Medicaid and food stamps. Between 1974 and 1994, the total number of persons receiving SSI checks increased by 96% and the number receiving SSI because of disability increased by 273%. The number of persons receiving SSI for a mental disability has also increased steadily over the years. This has been due in large part because persons being discharged from state psychiatric hospitals apply for and are approved for SSI benefits. (Torrey, 1997)

The Disability Insurance Trust Fund, which is part of the Old-Age, Survivors, and Disability Insurance (OASDI) program, commonly referred to as SSDI, was established in 1956 as a program to provide income maintenance to workers who had become disabled and whose disability was expected to last indefinitely. The largest diagnostic category of SSDI has been mental disorders. In 1994, 27% of all SSI and SSDI monies were paid towards mental disorders, other than mental retardation. (Torrey, 1997)

Recipients of SSI are eligible for food stamps, a program almost completely paid for with federal funds. It is estimated that 20% of those receiving food stamps also receive SSI. Since 30% of those receiving SSI are considered to have mental illness, then 6% of food stamp users also probably have mental illness. Estimates of Housing and Urban Development Funds that are used to support housing for persons with mental illness were 1 billion in 1994. The Veterans Administration also spends approximately 13% of its funds for care for veterans on those receiving help for psychiatric disabilities. (Torrey, 1997).

The consequences of funding changes have been profound. In 1963, the federal government, with the state and local agencies picking up 98%, paid for approximately 2% of services for persons with mental illness. By 1994, 62% was paid by the federal government, with 38% being picked up by the state and local agencies. According to E. Fuller Torrey, the results of this cost shifting has led to five main consequences:

- **Inappropriate discharge of patients.** After the enactment of Medicaid and Medicare, the deinstitutionalization of patients significantly increased. States gained by shifting the cost responsibility to the federal government. There were no gains for states in insuring that the patients received follow-up care. Many of these patients ended up on the streets, in public shelters, in jails or prisons.
- **Transinstitutionalization.** Many of the patients who were deinstitutionalized have actually been transinstitutionalized, which is being transferred to nursing homes or other programs in which federal dollars pay most of the costs.
- **Psychiatric treatment in general hospitals.** Medicaid pays for psychiatric care in general hospitals but not psychiatric hospitals. Costs are more in general hospitals than in state psychiatric hospitals. Many general hospitals turn away persons with the most severe mental illness.
- **Uncoordinated provision of care.** Prior to deinstitutionalization in the 1960's, public psychiatric care was run almost exclusively by the states in partnership with local counties or cities. Since that time, psychiatric care has become an assortment of categorical programs, which are funded by a variety of federal, state and local sources. Care for persons in need is determined by how reimbursement from the federal government can be assured. Upon dismissal from institutions, follow-up is often minimal, and financial barriers play a critical role. There is little if any fiscal incentive to provide follow-up care. Studies have shown that without medications, 53% of persons with severe mental illness patients relapse in 10 months and 85% within 5 years. Studies in New York and Chicago have shown that rehospitalization occurs within 30 days for 30% of patients and 40% within 6 months. Failure to follow up with discharged patients

has also led to an increase in homelessness, incarceration in jails or prisons and episodes of violence.

- **Labeling children as disabled.** Legislation in 1990 increased the number of children who can receive benefits under SSI. Originally limited to children with mental retardation, psychosis and organic brain syndrome, eligibility now also includes other diagnoses such as attention deficit disorder and personality disorders, but also is based on their ability to perform age-appropriate activities including social communication, cognitive and motor skills. In addition, in some cases, the responsibility for residential care for more severely disabled children could be shifted from the state to the federal government if the parent gave custody of the child to the state and the state would charge the money to the federal government under Title IV-E of the Social Security Act. (Torrey, 1997)

The shifting of much of the funding to the federal government has produced unintended and significant consequences. Because care is so often tied to funding, the care of persons is shifted among institutions to where care can be funded adequately. Too often these institutions do not communicate with one another regarding the patient's care, and the patient becomes lost in a fragmented and uncoordinated system. In addition, agencies providing care must compete for scarce dollars in federal, state and local systems, and as a result, often have not enough personnel to deal with the clients who need their help. The agencies that receive clients as they are shifted from one care agency to another may not have the expertise or trained personnel to treat the mental illness the clients present. Because the CHMCs are mandated to serve such a multitude of mental health issues, the care of the persons with real mental illness may not be able to access needed help in crisis situation. Without a concerted effort of state and local governments to seek out different arrangements using public, private, non-profit and for-profit resources, the situation will not improve. During the time the federal government has had the major responsibility for funding, the mental health crisis has grown worse, and without change, may falter further.

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