

CARE OF THE CHRONICALLY MENTALLY ILL—STILL A NATIONAL DISGRACE

John A. Talbott, M.D.

Writing in this space in 1973, Robert Reich, M.D., called the care and treatment of the severely and chronically mentally ill a national disgrace (1). Since then things have grown worse.

They have grown worse because, while deinstitutionalization has proceeded, states still have not found a way to enable monies to follow patients from state hospitals to community settings and because with the recent fiscal crunch, all levels of government have again placed a lower priority on mental health than on education, highways, police, fire, and sanitation. They have grown worse because with the budgetary constraints and the threat of loss of accreditation to state hospitals, states have predictably shunted money into state rather than community settings and, because with the current emphasis on cost containment in health care, chronic patients in need of long-term supportive care and treatment have been the first to be discriminated against by reimbursement mechanisms such as Medicaid. Finally, they have grown worse because despite the lesson learned over the past 20 years that chronic patients need a vast array of supportive services including housing, income, education, and vocational and social rehabilitation, in addition to a full range of medical and psychiatric services, there are only isolated examples in the United States of programs providing such comprehensive care.

Historically, many attempts have been made to care for the chronically mentally ill. A succession of institutions have been proposed as *the* solution to the problem. Community mental health centers were designed to replace state hospitals, which replaced almshouses and workhouses, which replaced prison-like outhouses. Each “solution” has failed to solve the problem. And the latest fashion, community care, will join their company if it is allowed to proceed in its present form. It may be a debatable question (2, 3)

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whether or not state hospitals have improved over the last 20 years, despite the fact that they now house fewer than one-third their previous population and have vastly improved staffing, now approaching a 1:1 ratio. But there is no question that the current care provided to chronic patients in the community, whether deinstitutionalized or never admitted, is inadequate.

In 1975 APA charged an Ad Hoc Committee on the Chronic Mental Patient to study the issues and to propose a national public policy. The committee commissioned eight new studies on key areas: where the chronic patients are, their needs, the programs that help them, the obstacles that impede effective treatment, the economic issues, the legal issues, what levels of government should have what responsibility, and the pros and cons of case management. These studies served as a basis for a national invitational Conference on the Chronic Mental Patient (4), held in January 1978 in conjunction with the President's Commission on Mental Health. A report emanating from the conference, in the form of a call to action for a public policy, has been reviewed and approved by all components of the APA (district branches, committees, Councils, the Assembly, and the Board of Trustees) and is published in this issue of the *Journal* as a position statement.

Care of the Chronically Mentally Ill—Still a National Disgrace

WRITING IN THIS SPACE in 1973, Robert Reich, M.D., called the care and treatment of the severely and chronically mentally ill a national disgrace (1). Since then things have grown worse.

They have grown worse because, while deinstitutionalization has proceeded, states still have not found a way to enable monies to follow patients from state hospitals to community settings and because with the recent fiscal crunch, all levels of government have again placed a lower priority on mental health than on education, highways, police, fire, and sanitation. They have grown worse because with the budgetary constraints and the threat of loss of accreditation to state hospitals, states have predictably shunted money into state rather than community settings and, because with the current emphasis on cost containment in health care, chronic patients in need of long-term supportive care and treatment have been the first to be discriminated against by reimbursement mechanisms such as Medicaid. Finally, they have grown worse because despite the lesson learned over the past 20 years that chronic patients need a vast array of supportive services including housing, income, education, and vocational and social rehabilitation, in addition to a full range of medical and psychiatric services, there are only isolated examples in the United States of programs providing such comprehensive care.

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The committee sought to achieve consensus but in certain instances took controversial positions, which may seem provocative to some readers. For instance, the statement calls for an end to the government's conflict of interest in both operating and contracting for mental health services (at federal, state, and local levels); it calls for *local* government to designate who shall provide services for chronic patients. It also calls for private practitioners to be encouraged in caring for this population; for the adoption of a case management approach rather than case managers; and for an end to discriminatory reimbursement for long-term treatment and chronic care, coincident with the introduction of innovative methods (e.g., a voucher system) to provide appropriate care settings such as halfway houses and apartments for patients, rather than nursing or board-and-care homes.

The bulk of the statement, while sweeping, detailed, and comprehensive, will probably not incur dissent, for it addresses in detail the measures needed to reverse the current situation. It suggests that financing may be the key to most of the problems encountered by chronic patients. More money is not necessarily needed, but existing monies certainly must be redeployed from restrictive, inappropriate settings to a range of graded opportunities. The statement also suggests that discrimination against the chronically ill in health insurance, housing, vocational rehabilitation, and employment needs to be reversed. It redefines roles for all levels of government: the federal government to become responsible for national priorities and guidelines; state governments for regional priorities and plans; local governments for designation of providers; and the actual services provided by contract by the smallest entities possible (e.g., catchment areas). It challenges psychiatry to

engage in two previously neglected areas: training and research related to chronic illness. The statement recommends that psychiatric residencies incorporate experience with the chronically mentally ill in community settings and that research efforts be directed toward patient outcome studies, comparing different treatment modes and analyzing model service systems. It also encourages psychiatrists and psychiatry to become involved in planning and delivering services to chronic patients, even though these patients' primary problem may involve disability, not disease. And finally—but most important in the long run—it calls for a vast program of professional and public education regarding chronic mental illness and disability, without which none of the above will be realized.

The statement was intended as a comprehensive blueprint for public policy. It will be successful only if it is translated into effective action through legislation, governmental procedures, and professional initiative. While deriving *from* APA, it is not solely *of* APA, and it will become a reality only if all psychiatrists and all mental health workers and professional organizations fight for the adoption of each of its broad policies and detailed recommendations.

References

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