Pioneering a Clear Conceptualization of the Needs and Treatment of Persons With Serious Mental Illness

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Well before anyone else, John Talbott had a clear grasp of the problems that deinstitutionalization posed for persons with long-term and severe mental illness and what was needed to solve these problems. Much of this understanding emerged from the 1978 American Psychiatric Association (APA) Conference on the Chronic Mental Patient, which Talbott organized and led.

At the time of the conference, the mental health field—and society—were just beginning to confront the effects of deinstitutionalization on persons with long-term and severe mental illness who had been discharged from their "homes" of many years in the state hospitals. The field was also beginning to confront its effects on those who had reached young adulthood in this new era, when most persons with severe mental illness no longer lived out their lives in state hospitals. The effects of deinstitutionalization were not yet clearly understood, and it was John Talbott who led the way in conceptualizing and writing about these issues, as in the four papers that precede this commentary.

Talbott understood how deinstitutionalization had become the disaster that it was. There had been "no true testing of the tenets later given as the philosophic underpinnings of deinstitutionalization: for example, that community care is better than institutional care, that community care costs less than institutional care, and that care in the least restrictive setting is of higher quality." Likewise, there was no clear conceptualization as to what community care should consist of, and there had been little or no planning before or during deinstitutionalization. With the patients out of the hospital, community facilities had not begun to keep pace with the increased numbers of discharges and decreased numbers of admissions. Moreover, persons with mental illness who had had their needs met in one place—the hospitals—were now expected to seek out a host of community services that were not coordinated and were to be found in a variety of agencies. No comprehensive and integrated system of care—with designated responsibility, accountability, and adequate fiscal resources—existed in the community for persons with long-term and severe mental illness. As Talbott put it, "the disaster occurred because our mental health delivery system is not a system but a non-system." Deinstitutionalization also revealed the rank discrimination against long-term care and chronic illness by the mental health field, by governmental and private third-party reimbursers, by housing agencies, and by potential employers.

Furthermore, Talbott understood that if nothing was done, the problem would only get worse. The population of the United States was—and still is—exploding, and the number of persons with long-term, severe mental illness who were growing up in the postdeinstitutionalization era was also helping to overwhelm those community facilities that did exist. Talbott repeatedly warned of the consequences of closing the hospitals without using the funds saved to treat the severely ill population.

Talbott was not one to accept these problems passively. At a time when leadership was called for, he provided it. After the APA Conference on the Chronic Mental Patient, he lobbied vigorously and tirelessly all who would listen. He spoke with persons at all levels of APA, including the assembly, the board of trustees, and the membership, by means of presentations at the annual meeting, the conference report published in *Hospital and Community Psychiatry* (now *Psychiatric Services*), and the widely distributed book *The Chronic Mental Patient: Problems, Solutions, and Recommendations for a Public Policy.* When Talbott became president of APA in 1984, he continued his advocacy for persons with long-term and severe mental illness. Among his other efforts in this area, he appointed a task force on the homeless mentally ill, which drew considerable attention to a situation that had become a major problem in the United States.

When Talbott became Editor of *Hospital and Community Psychiatry* in 1981, one of his highest priorities was to address these problems. Over the past few decades, persons with severe mental illness have gone from being sub-

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jects of very little interest and subjects of neglect in community mental health to one of the field's highest priorities. I believe John Talbott should be given much of the credit for this important shift.

Talbott was also clear as to what needed to be done from a treatment point of view and gave the field a conceptualization of what community treatment should consist of. First of all, he strongly advocated that there be a comprehensive and integrated system of care for persons with long-term and severe mental illness, with designated responsibility, accountability, and adequate fiscal resources. The following are the components of such a system as he saw it and as it is generally accepted today.

Adequate, comprehensive, and accessible psychiatric and rehabilitative services must be made available. First, there must be an adequate number of direct psychiatric services that provide outreach to persons with severe mental illness in the community: psychiatric assessment and evaluation; crisis intervention, including hospitalization; individualized treatment plans; psychoactive medications; and psychosocial treatment. Second, there needs to be an adequate number of rehabilitative services that provide socialization experiences, training in the skills of everyday living, and social and vocational rehabilitation. Third, an adequate number of professionals and paraprofessionals must be trained to provide community care to persons with chronic, severe mental illness. Fourth, the difficulty of working with some of these patients must not be underestimated.

General medical assessment and care must be readily available, given that we know that the long-term and severely mentally ill have much higher rates of morbidity and mortality than the general population.

Talbott emphasized that an adequate number and ample range of graded, stepwise, supervised community housing settings must be established for individuals who are not ready for independent living. Thus there should be a continuum of types of living arrangements that offer different levels of supervision, both more and less intensive, including halfway houses, board-and-care homes, satellite housing, foster or family care, and crisis homes.

Talbott saw that a system of responsibility for persons with long-term and severe mental illness who are living in the community needs to be established, with the goal of ensuring that each patient ultimately has one mental health professional or paraprofessional (that is, a case manager) who is responsible for all aspects of his or her treatment plan and care.

Earlier than most mental health professionals did, Talbott understood that for the families of the more than 50 percent of the long-term and severely mentally ill population living at home, respite care and other programs need to be available to the families to enhance their ability to provide support. He believed that the entire burden of deinstitutionalization must not be allowed to fall on families.

Talbott believed that basic changes needed to be made in legal and administrative procedures to ensure continuing community care for persons with long-term, severe mental illness. In the 1960s and 1970s, more stringent commitment laws and patients' rights advocacy remedied some very serious abuses in public hospital care. At the same time, however, these changes neglected patients' rights to high-quality, comprehensive community care as well as the rights of patients' families and of society. Talbott, therefore, advocated that new laws and procedures be developed to ensure provision of psychiatric care in the community—that is, to guarantee a right to treatment in the community.

A system of coordination among funding sources and implementation agencies must be established. Because the problems of persons with long-term and severe mental illness must be addressed by multiple public and private authorities, coordination—which was so lacking in the deinstitutionalization process—needs to become a primary goal. The ultimate objective must be a true system of care rather than a loose network of services, sometimes working at cross purposes, and an ease of communication among different types of agencies—psychiatric, social, vocational, and housing.

Other parts of Talbott's system included ongoing asylum and sanctuary for that small proportion of the chronically mentally ill population that does not respond to current methods of treatment and rehabilitation, expanded research into the causes and treatment of chronic mental illness, and the gathering and analysis of more accurate epidemiologic data.

Finally, Talbott insisted that additional monies be expended to finance the system of care he envisioned.

Clearly, John Talbott was well ahead of the field, not only in his understanding of the needs of persons with long-term and severe mental illness but also in his editorship of *Psychiatric Services,* where his grasp of all aspects of our profession was what enabled him to make this journal into one of the leading journals in psychiatry and mental health. I believe there is no question that John Talbott is the Adolph Meyer of our time. ♦

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