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The Pendulum Swings: How Changes in Federal and State Policy Have Affected the Status of Homeless People with Mental Illness in Ohio

Kim Bryant
Greater Cincinnati Coalition for the Homeless

The Pendulum Swings

The Effect of Changes in Policy on Homeless People with Mental Illness in Ohio

Kim Bryant, M.S.W., L.I.S.W.

Public policy in the problem areas of homelessness and mental illness has been reactive, rather than proactive, for the past thirty to forty years. As a result of this approach, federal and state policies have swung, like a pendulum, from one extreme to the other, taking the homeless mentally ill population on a most difficult ride. Public policies concerning these issues must become proactive, even if it means a complete overhauling of federal and state social service systems. Only with proactive policies will mentally ill individuals, and all people, have the housing, food, and health care they need, and the dignity to which they are entitled.

For the past five decades, federal and state policies on housing and persons with mental illness have swung from one extreme to the other, in attempts to alleviate the problems of mental illness and lack of affordable housing. These drastic changes in public policy have profoundly affected the homeless population who are also mentally ill. Over-the-Rhine, the poorest, most depressed area in Cincinnati, Ohio, is where Tender Mercies, Over-the-Rhine Housing Network, and the office of the Greater Cincinnati Coalition for the Homeless are located; it is where I most clearly see the struggles that the poorest of poor, the homeless, must face.

Tender Mercies, Inc., is a nonprofit organization providing permanent and transitional housing for people who are homeless and suffering from mental illness. The agency began in 1985, when three Catholic priests who lived in the neighborhood helped two homeless mentally ill women find apartments in the same building. When, shortly afterward, one was raped and murdered and the other assaulted, the priests decided to do something. They approached the owner of the building and asked to manage it at no cost to the owner; they would guarantee 100 percent occupancy and rent payments as long as the owner agreed to let them choose the residents. The owner agreed, and Tender Mercies was born.

Tender Mercies now owns and/or manages seven buildings, with a total of 128 units of housing, in Over-the-Rhine. The agency provides social services, a recre-

Kim Bryant, former executive director, Tender Mercies, is treasurer, board of the Over-the-Rhine Housing Network, and a member of the coordinating committee, Greater Cincinnati Coalition for the Homeless.

ation center, and other mental health services. Tender Mercies received no support from any mental health funder until 1988. Much of the original funding came from local corporations and private donations. Today, Tender Mercies funding comes in small percentages from the city of Cincinnati and United Way. Donations, rents, foundation grants, and purchase of service agreements with the Hamilton County Mental Health Board make up the rest.

To fill the gaps created by the swinging pendulum in federal and state policies, Tender Mercies has developed a spectrum of services. One is a transitional housing program offering a full range of support services, including on-site psychiatric and case management services, as well as twenty-four-hour staffing to provide safety, companionship, and a sense of security. The funding for this program came primarily from the Robert Wood Johnson Foundation with a small grant through the McKinney Act and some moneys through the state of Ohio. Ironically, after assisting in the setup of this program, the state of Ohio informed us it would no longer support transitional housing or any housing with services attached. These services frequently provide the support needed for clients to accomplish their individual aims.

One of the clients who was able to use the transitional housing service to achieve her goals was Brenda, who came into my office at Tender Mercies. The lobby staff had not recognized her when she came to let me know that "miracles do happen." Remarried and again employed as a licensed practical nurse, she is planning to return to school for her certificate as a registered nurse.

I remember when she showed up on our doorstep several years ago, while I was the director of our transitional housing program. She had been sent by the shelter down the street, a mass shelter serving mostly men and certainly not equipped to handle her issues. Brenda was wearing a fur coat (it was August); she had dirty stringy brown hair and grit ground into the creases and pores of her face and hands. The dark blue circles under her eyes seemed to hang down to her knees, but maybe that was because she was stooped so low that she looked as if she might fall over. She said she needed a place to stay. We told her to come in and we would try to figure something out.

She moved in with the clothes on her back and began to look after me. Our relationship grew. She let me know she had been a nurse and that I really needed to take care of myself; she could "see it in my eyes." I would agree, then ask her how she was taking care of herself. For months she watched me, advising me on my health, among many other things. At the same time, she refused medication and didn't reveal much; through hospital records we knew she had been diagnosed as having bipolar affective disorder.

People with this disorder are often manic-depressive, that is, they swing in mood from extremely depressed to extremely active. People with the most severe cases do not function well in their day-to-day lives when they are in the depressed state; in the manic state they seem to be able to accomplish impossible tasks with ease. Many people whose symptoms are under control or who do not have severe symptoms do very well. Some individuals with the more severe symptoms also have psychotic-like symptoms accompanied by hallucinations.

We didn't know how difficult it had been for Brenda until one day we found her in the hallway, huddled in a small ball, as small as she could make herself, screaming. She said that we were under attack; machine guns and bombs were falling

around her and she knew she was going to die. We all made it through that first attack, but there were more to come.

At one point she almost had me convinced of a petroleum spill. She came into the office, after standing around outside, to tell another staff person and me about the petroleum that had fallen on her — "Just a little, you see." We began to get suspicious as we asked her to describe what happened. When she began a complicated story about the redness of the sky and the streaks of the petroleum coming from something concerning astronomy, we felt fairly sure that it was not within our reality. Brenda was a very bright and compassionate person. There were more than a few times when the staff and I really had to mull over whether our reality was in question, or hers.

Eventually, through all of this, Brenda began taking medication that eliminated the hallucinations and helped to level the mood swings, and she began to make plans for leaving. Hearing that we were making a public service annoucement for television, she asked to be a part of it. She wanted to "give back some." I sent the cameras to her room while I remained in the hallway.

Brenda related the beginning of her journey to our door, which she had never told us. She talked about working as a nurse, her large home, and her corporate lawyer husband. Then she became ill and was hospitalized. On her return home while her husband was at work, she found something wrong with the lock on her door, because her key wouldn't open it. She went to a neighbor's house and called her husband. His reply was "Honey, you don't live there anymore."

Locked out of her home with nothing but what she had taken from the hospital, and no follow-up from the hospital, she began the "shelter shuffle," going from shelter to shelter trying to access housing and help. Along the way she lost her dignity and her delicate grasp on reality, until she arrived at our door.

Brenda's story is and is not typical. Many people walk the same paths and face similar obstacles, yet each one's story is different and unique. In her life the pendulum swung from one extreme to the other, but Brenda was able to hang on. That is what is not typical. Many people like Brenda lose their grip while waiting for the pendulum to swing.

How have our national policies and practices affected those who are unable to hold on? When talking about the "homeless problem," most people quote numbers, ranging nationally from 250,000 to 3 million people. There is constant argument over the numbers to the detriment of the people whose stories are forgotten. Housing and service dollars are siphoned off to count people without homes rather than providing homes and services. Why can we not simply agree that there are too many people without homes and then get on with the task of providing needed services?

The 1980s represented a decade of despair and hopelessness for poor people and one of hope and financial gain for the rich. The extremes became more extreme and the middle shrank. The poorest 20 percent of Americans receive less than 5 percent of the nation's income, while the richest 20 percent receive more than 40 percent.[1] Ronald Reagan's trickle-down theory and practices did not mean that resources would trickle down but that more people would trickle down to the poorest extreme.

During the eighties an estimated 400,000 families were cut from Aid to Families with Dependent Childeren and food stamp benefits were reduced or eliminated for about one million people.[2] The federal budget financed 200,000 new and rehabilitated low-income housing units a year in the 1970s, but only 27,000 per year by 1986.[3]

Complicating this picture of available low-income housing is the fact that many units put into operation in the 1960s went out of service in the 1980s and that many of the units financed in the 1970s will be going off line in the 1990s. The loss of these units is a direct result of using low-income housing subsidies to subsidize for-profit developers. The provisions in the subsidies by the federal government allowed developers to turn the units to market-rate housing after twenty years of operation. Unless the federal government replaces those units going off line, there will continue to be loss of affordable housing and an increase in the number of poor and of homeless. Changes in these policies over the last decade can be held directly responsible for a large portion of the blame for the increasing homeless population.

The changes in state and federal mental health policies comprise another important factor contributing to the increasing homeless population. The swings of the pendulum in this area have resulted in many mentally ill people joining the ranks of the homeless. The percentage of persons with mental illness among the homeless population has been estimated from as high as 56 percent in some cities to 25 percent in others.[4]

In my opinion, changes in policy that reflect changing assumptions about appropriate interventions, amplified by cultural shifts and attitudes toward institutionalization, as well as statutory changes and interpretations, have resulted in an ever increasing population of people who are homeless and mentally ill. In reviewing the histories of institutionalization, the practice of treating mental illness, and the treatment of the poor in this country, as well as my experiences in working with systems charged with the responsiblities of doling out what meager resources are made available to them, it has become obvious to me that drastic and far-reaching changes must be made. The individuals whose stories appear in this article are examples of only a very small portion of the true injustices, pain, and sorrow so many must face in their day-to-day struggles to survive.

Jean Isaac and Virginia Armat give the following historical context for understanding the changes in the treatment of mentally ill persons, by both psychiatry and the law, in *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill.* The information contained in their book, as well as my own experiences, has brought me to the following conclusions. In the last forty years, many advances have been made in treating people with mental illness. By the 1950s, we had affirmed the biological basis for mental illness and discovered drugs to help alleviate its symptoms. We established hospitals to care for people with mental illness and were optimistic and excited about the answers we found. Mental illness was truly a disease and could be treated as such with hospitalization and medication. What a relief it was that we were finally able to do something. By 1955, 559,000 people were in state mental hospitals.[5]

My family was among many who during this time gratefully sought help for a family member with mental illness who was then hospitalized for "treatment." My grandmother was forcibly hospitalized after losing touch with reality shortly after the birth of her last child. When she dressed her youngest daughter in winter clothing and believed her to be freezing to death in the midst of summer, it became apparent that she needed help. She was taken away by several men in a large black car and remained hospitalized for a large part of her life. When long-term hospitalization was no longer considered appropriate treatment, she was placed in an adult foster home to live out her remaining years.

The 1960s saw the birth of the "antipsychiatry" movement, which took hold of public policy and has not let go. The sixties brought about, among other things, a counterculture whose members discovered the use of LSD when it was first introduced to them by their psychoanalysts. The effects of LSD and other psychedelics spread outside the control of physicians and further fueled the growing counterculture. The effects of the drugs on relatively sane people included intense anxiety, paranoia, and hallucinations. The effects were so similar to those of mental illness that LSD was believed by some to hold the answers to a controlled study of mental illness. For example, a federally funded project established at a veterans hospital in Menlo Park, California, paid volunteers to take LSD so that researchers could study its effects.

Ken Kesey, author of *One Flew over the Cuckoo's Nest*, was among the volunteers. Shortly after participating in the research, he began working on a ward of psychiatric patients. It was after those experiences that he wrote the book which was later made into a movie about a man who attempts to free the "victims" on the psychiatric ward.

As the counterculture became political, the mentally ill and their victimization were thrown into the political arena and psychiatry became one of the enemies, going from savior to devil. This belief was even substantiated by some psychiatrists, led by Ronald Lang and Thomas Szasz. Their influence on the treatment or lack thereof for people with mental illness is still strongly felt.

The antipsychiatry movement led to a significant decrease in the credibility of psychiatry and to the association of mental illness with civil rights. Hospitals were seen as jails where people were held against their will with very little recourse and for no reason. Many stories were told of mistakes made in committing people who were perfectly sane, and published accounts detailed horrible conditions in hospitals owing to overcrowding. The dream of the forties and fifties became the nightmare of the sixties and seventies, and the pendulum began its journey toward the reality of today.

In the sixties, deinstitutionalization became the course of action supported and encouraged by President John Kennedy through his efforts at establishing community mental health centers, and reducing the population of people in mental hospitals. As of 1984, it numbered 116,000[6] as compared to 559,000[7] just twenty-nine years earlier.

The realities of deinstitutionalization have been much different from its seemingly intended effects. What awaited the deinstitutionalized person was not a warm welcoming community able to provide the needed treatment, but one that conveniently turned its back in an effort to protect its wallet. The needed dollars have not flowed to community services or housing in a way that would establish the needed support, treatment, and services for people leaving the hospitals and entering the community. Although community service represents 75 percent of the services provided to people with mental illness, it receives only 30 percent of the funding dollars.[8]

Paralleling the changes in treatment preference and modalities were changes in the laws and/or interpretation of the laws. We swung from the requirement of treatment or institutionalization, often court-ordered, to the right to refuse treatment regardless of one's ability to determine reality unless the person poses an imminent danger to self or others. In Hamilton County, Ohio, of which Cincinnati is the county seat, this has been interpreted, at least by local physicians, to mean being homicidal or suicidal, with a plan and the perceived means of carrying it out.

In Ohio the law allows physicians or designated health officers (police officers and trained and certified others) who believe that someone who is known to be mentally ill, and is a danger to self or others or unable to care for basic needs, to sign a "hold" statement. It specifies that the person be hospitalized for seventy-two hours for observation to determine the need for further hospitalization. Once a hold is signed, the police can take the person, against his or her will, to a hospital. The only other option to force someone to obtain treatment is to go through the court system and have a judge order treatment. Hamilton County has one of the highest court-ordered treatment rates of counties in Ohio, according to its Community Mental Health Board, yet people needing medication adjustment and further stablization provided by even a slightly longer stay in the hospital are being released without appropriate follow-up or are unable to access such needed services.

While working at Tender Mercies and attempting to obtain appropriate treatment for our residents, I would frequently run into this roadblock. We would have someone who was totally out of touch with reality, unable to care for personal needs, including medical needs, and we would be unable to activate the service delivery system because the person "did not fit the hold criteria." At times we were told this over the phone, without an evaluation of the individual needing services from the service provider. It seem to me that this practice stems from the interpretation of hospitalization as incarceration and that physicians and police are therefore fearful of violating a people's civil rights by hospitalizing them against their will unless they have committed, or admitted an intention to commit, a crime. The results are that unless an individual has reached the extreme of behaviors or is enough in touch with reality to volunteer to seek hospitalization, the door to possible assistance is closed.

In my opinion, this situation has been exacerbated by the closing of Rolmans State Hospital, one of the two state hospitals in Hamilton County. A facility designed to treat acute cases of mental illness, it was closed in an effort by the state to save money. Most of the staff and patients were transferred to the Pauline Warfield Lewis Center, a facility designed for long-term care, and not for severe acute cases. What was not well publicized was that many Lewis Center patients were discharged the year before Rolmans was closed. I found out about the discharges when I was discussing what I saw as an increasingly difficult and aggressive population of mentally ill persons coming to Tender Mercies' doors from the streets with the then medical director of Lewis Center. He informed me that he had been releasing "more patients over the last year" and wondered "how things were going in the community." I believe that the releases at Lewis Center had less to do with the needs of the patients and the ability of the community to provide the service and more to do with the anticipated closing of Rolmans and the need to make room for the transfers.

An example of the effects of this policy is a former resident of Tender Mercies who came to see me. He informed me that he had been discharged from the remaining state hospital that day and was told to go to the local mass shelter. One of Tender Mercies' staff followed up, and after several long calls to the hospital found that a room had been rented for him in a low-income downtown hotel for one night, but apparently no one had told him. In addition to being mentally ill, he also had an impaired IQ. His discharge was supposed to be provisional; if he could survive, he would be discharged to the community.

This man had left us previously, when he was in a very poor condition. After repeated urging and pleading by Tender Mercies' staff with his case manager, he was finally hospitalized after becoming so violent that he broke the ankle of one of my staff members with a metal chair. He is now back in the community with little or no follow-up to see if he can "make it," and we are urging and pleading again.

Ironically, despite the closing of state hospitals and lack of appropriate community services, Ohio has been ranked as one of the best places for services for people with severe mental illness. Since working at an agency that assists people who are supposed to be receiving these services, I find it difficult to understand how Ohio gained this ranking. It seems to me that we have not solved the sins of the institutions; we have only changed their face. Today the streets exist as an institution for many people with severe mental illness. The difference is that they have no bed to sleep in at night, no steady source of food, and their risk of physical harm has been increased. We have also designated jails as an alternative to institutions or hospitals.

An example of jails as an alternative in Cincinnati is the revival of an old panhandling law. Because some upstanding citizens complained about the panhandlers on city streets, police began arresting and jailing individuals who fit that description. Homeless activists and concerned others approached our city council for assistance; eventually, after much publicity in the local newspapers, the police significantly reduced their enforcement of the old law. Recently there has been discussion of a voucher system for panhandlers that would allow well-meaning or guilt-ridden citizens to buy and donate to panhandlers vouchers that would entitle them to, for example, a meal.

Cincinnati's criminal justice system is incredibly overcrowded without this influx of panhandler "criminals." There is no room in the jails for rapists and other perpetrators of violent crimes. Those wishing to file charges for assault are referred to private complaints; they meet with a mediator while the perpetrator roams free, rather than criminal charges being being filed and the perpetrator going to jail. Clearly, everyone, including local citizens, police, politicians, and mental health and homeless activists, is frustrated by the lack of options for persons who are homeless, particularly the homeless mentally ill. How else can we explain such extraordinary measures as jailing panhandlers when rapists and other perpetrators of violent crimes go free? One of the residents at Tender Mercies was actually jailed for thirty days for jaywalking!

Ohio has a "housing as housing" policy for the treatment of persons with severe mental illness. The state previously provided dollars for such services as halfway houses, group homes, transitional housing for people who were homeless and had a mental illness, and supervised living with staff on the premises, including on-site case management. It seemed we had it all. It has been defunded by the state. There are now no programs with on-site service that the Ohio Department of Mental Health does or will fund.

The reason is the housing as housing policy, as well as decentralization of funding and services and a reduction in available state funds. The policy basically says that the state will provide funding only for housing without services attached and that any services provided have to be based somewhere else. The state will no longer fund any housing with "programs." According to the position paper describing the policy, "In summary, the Department intends to direct the large majority of its resources to development of housing as housing. Exceptions to this will be rare."[9]

The intent of this policy is to "promote the availability of decent, stable, affordable housing for all persons with mental illness including those with severe mental disabilities."[10] The department is acting as a funding source for low-income housing for persons with mental illness. This, in and of itself, is an applaudable act; however, it has taken valuable resources away from community support services that were already insufficient, and it fails to coordinate services with housing.

While this policy change was taking place, the state began decentralizing services and reducing funding. The state hospitals are being turned over to the counties in which they are located or are being closed. As a result of these changes, the community mental health boards, which were initially designed to provide services within the community setting, are being burdened with the responsibility and the cost of the hospital closings and the resulting flood of people needing services. In addition, the state announced budgetary reductions, resulting in a large reduction for the Hamilton County Community Mental Health Board, and for all its contract agencies providing community support services. In sum, state-level cuts are forcing clients out of hospitals and cutting the much needed support services provided by community mental health programs. With the Hamilton County budget cuts, treatment options are being eliminated, and almost the only way to access treatment is again through the court system. It is not surprising that the county has one of the highest court-ordered treatment rates in Ohio. It is often the only option available.

One of the residents of Tender Mercies set fire to the building he lived in. When he was asked why he did it, he said that the voices in his head told him it was the only way he would receive help. He had been at the local state hospital for a while, but was released, still hearing voices. He went to the local psychiatric emergency room, was hospitalized for a few days, then discharged. He went to a private hospital, which refused to admit him. When he returned home, he propped his door open with his small refrigerator and started a fire in his doorway. The hallways had a twenty-four-hour smoke/fire monitor system. He was promptly arrested and taken to jail for aggravated arson.

In a separate incident, a man in a different Tender Mercies building set a fire that resulted in $50,000 worth of property damage, physical risk to thirty-one people, and displacement of thirty people to other living arrangements. Tender Mercies staff had been pleading for appropriate services for him for several months. After the fire he was hospitalized for a short time; when he was released he moved into a building down the street. His new apartment was over a bar (he was also actively alcoholic). Within a week he started another fire in his apartment and was arrested for arson. If he was lucky, he would be probated by the court and receive the treatment and services he deserves.

Hamilton County is among the best in Ohio in the provision of services. Other counties, particularly rural ones, are having a much worse time. Clermont, a rural county that neighbors Hamilton and has a high proportion of poor people of Appalachian descent, suffered a failure of the county tax levy when voters failed to approve its passage. The county had to close some of its community mental health clinics. Such situations are mirrored across the state.

It is no mystery why the population of homeless people, specifically those with mental illness, has increased, given the changing policies and resulting lack of available support services and housing. The lack of a well-coordinated system of service

delivery, locally and nationally, brought about by the inability of people to access services, results in more people being homeless.

We must stop the pendulum from swinging again and again to the extremes. Today there is much talk about the need to reinstitutionalize many severely mentally ill people, particularly those who are homeless. So already the pendulum begins its decline. To address the issue of homelessness, we must address the true issues. To begin to alleviate the difficulties faced by so many people without access to the tools for basic survival, we must first acknowledge the right to these tools. Food, shelter, and security are the building blocks for all human endeavors. All must have access to these as a human right, if for no other reason. We must provide the needed dollars for development of permanent affordable housing and provision of adequate food and health care, including mental health care. In addition, we must provide an overlay of funding for education and vocational training for all who are in need.

I am proposing radical changes not only in the mental health system but for all service delivery systems. We must build a system, nationally, that coordinates, monitors, and funds programs providing for our citizens' basic human needs, including decent affordable housing, food, health care, education, and employment. The United States currently funds one of the largest military communities in the world and derives very little social benefit from it. We must learn from the failures of the Soviet Union, one of the other military communities that robbed its citizens of the basic tools of survival. The Soviets did not come to the bargaining table due to our military might, but because their economy toppled in supporting such a military community. We are headed down the same path. We are fighting a "war on drugs," sending people to live in space at extraordinary expense, bailing out banks and savings and loans, paying farmers not to grow food; the list goes on. Elimination or substantial reduction of spending on these endeavors would allow us to begin anew, to guarantee our citizens decent affordable housing, food, health care, education, and vocational training. We would no longer need welfare handouts or the stigma attached to them; instead, as with Social Security, we would have certain rights and not have to apologize or plead for the basic tools of survival. The social and economic benefit would be tremedous.

To return to reality: given that we are not going to begin anew anytime soon, what can we do with what we have? We must work to increase the funding of affordable housing and not allow developers to take future funded units off line; they must remain affordable housing. The federal government must get back into the game of funding affordable housing, and states must continue to look for creative ways to finance it.

The National Institute of Mental Health must receive the funding needed not only to carry on research and technical assistance, but to establish minimum standards and the ability to monitor and fund programs for community support. These must include the following.

1. Case managers for persons who are chronically or severely mentally ill should average no more than twenty-five clients per caseload.

2. Skill training, and other housing support, must be made available to all who need it.

3. Psychiatric backup, separate from attending psychiatrists at emergency rooms, should be available to case management teams twenty-four hours a day. In addition, psychiatrists should be available to see their patients as often as necessary.

4. A range of treatment options, including housing, should be available to people based on their needs.

5. Laws pertaining to forced treatment should be redefined to address the issues of danger to others and self and to include being detached from reality and unable to determine appropriate treatment, as well as being unable to care for self.

We must centralize the coordination of services, without a huge bureaucratic overlay, so that services can be provided effectively and compassionately. We must say no to the swinging pendulum and find the steady ground based on long-term solutions, not short-term politics. ❧

Notes

1. R. B. Reich, "As the World Turns," *The New Republic,* May 1989, 23–28.
2. Patrick Dattalo, "Moving Beyond Emergency Shelter: Who Should Fund Low-Income Housing?" *Social Work* 36, no. 4 (July 1991) : 297–301.
3. F. G. Reamer, "The Affordable Housing Crisis and Social Work," *Social Work* 34 (January): 5–9.
4. J. Morrissey and D. Dennis, "NIMH-funded Research Concerning Homeless Mentally Ill Persons: Implications for Policy and Practice" (Washington, D.C.: U.S. Department of Health and Human Services, December 1986), 15.
5. Jean Isaac and Virginia Armat give an excellent historical context in *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (New York: Free Press, 1990). It is well worth the reading and gives a much more in-depth view of these events.
6. Committee on Government Operations, "From Back Wards to Back Streets: The Failure of the Federal Government in Providing Services for the Mentally Ill" (Washington, D.C.: U.S. Government Printing Office, 1988), 3.
7. Isaac and Armat, *Madness in the Streets.*
8. Committee on Government Operations, "From Back Wards to Back Streets," 14.
9. Grace Lewis, "Housing as Housing: Discussion Paper," Ohio Department of Mental Health, July 1988, 7.
10. Ibid., 1.