

# Cause for despair, reason to hope.

Taking stock of a de facto  
mental health system

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# Circumlocution Office (*Little Dorrit*, 1855-57)

“Numbers of people were lost in the Circumlocution Office. Unfortunates with wrongs, or with projects for the general welfare . . . who in slow lapse of time and agony had passed safely through other public departments; who according to rule, had been bullied in this, over-reached by that, and evaded by the other; got referred at last to the Circumlocution Office, and never reappeared in the light of day. Boards sat upon them, secretaries minuted upon them, commissioners gabbled about them, clerks registered, entered, checked, and ticked them off, and they melted away.”

# Framing an inquiry

- Two kinds of applied anthropology
  - The better known brings a spoiler's sensibility to its reading of psychiatric procedure: dusting for cultural fingerprints on the premises of clinical practice. (Parallels with social control/deviance literature in sociology.)
  - A second, lesser-known tradition: sees contemporary community psychiatry as unusually hard repair work in socially suspect precincts (Rhodes 1990; 2004; Luhrmann 2000; in press; Ware et al. 2000; Robins 2001; Hopper in press), work that has pointedly moral overtones. (Parallels with "dirty work" tradition in sociology.)

# Background

- Dawn of the “deinstitutionalized” era
  - A transfer of care/custody – not so much “post” as “other”: where/what were substitute institutions?
- The unplanned birth of a “de facto mental health system” (Regier et al. 1978)
  - Especially where those “out of service [or in] other human service” may be found

# Mapping “de facto” systems

- Defined by actual patterns of use, exercises of custody, provision of care + support
- Working assemblages of resources, services and facilities – enabling persons with SMI to survive “in community” or provide for keep elsewhere
- Sometimes organized (ACT teams); often makeshift (retrofitted shelters “TLC’s”); or default improvisations (SHUs in jails + prisons)

# So what's distinctive?

- No one signature institution – no functional equivalent of a (very convenient “field site”) psychiatric hospital
- Cross-sector relationships – ill-defined, contested, continually (informally) negotiated
- Implications for research – improvise, redefine domains and functions, sort out actual work from assigned/proclaimed jobs

# Managing risk

- In a de facto system, “social control” functions (Horwitz) are distributed, diffuse and intersect with other assigned responsibilities
- Specifically: public safety competes with indigent care as defining charge of public MH system
- Example:
  - Kendra’s Law (Gresham) and the tortured odyssey of Andrew Goldstein

# Re-examining event-driven policy

- The official inquiry into “what went wrong” (State Commission on Quality of Care, November 1999):
  - Despite a documented history of mishandled clinical responsibilities, this is mainly a story of acceptable risks in system driven by cost-containment
- Journalistic reconstruction, using hospital chart of uncertain provenance (Winerip, *NYT Magazine* May 1999):
  - Setting aside abundant instance of poor judgment: it’s the standing inadequacy of resources already proven to work – not poor science or inadequate knowledge, but agents and systems informed by evidence
- And this curious fact: Goldstein had been assessed in Bellevue ER, 9/12/98, during Pilot Study of OPC – and found ineligible

# The example of homelessness

# Research (1)

- Hopper et al. 1997:
  - 36 consecutive SMI applicants for shelter, Westchester County, 1995, 5-year residential history
  - 20 (56%) spent on average 3 years of that period (60%) in various institutions, shelters, or on street = “the institutional circuit”

# Research (2)

- Herman et al. 1998:
  - 237 first-admissions for psychosis in Suffolk County, followed for 2 years,
  - 17% on street or in shelter, either just before study entry or during follow-up; no diagnostic differences

# Research (3)

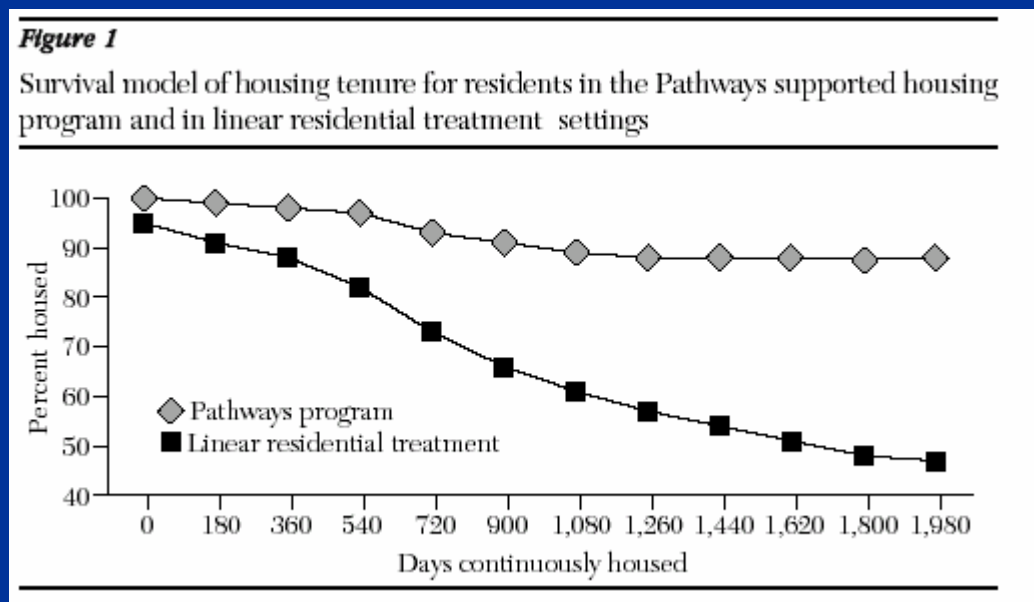
- Folsom et al. (2005):
  - 10,340 outpatients with SMD, public mental health system, San Diego (1999-2000); excluded 1,952 in “justice-related facilities” [sic] (jail, locked wards, rehabilitation facilities)
  - 15% at least “one recorded encounter” with MH system while on street or in shelter; 20% in those with schizophrenia

# So: what's the problem?

- If defined as lack of “housing readiness” on the part of SMI homeless persons – a peculiar disability, then fix impaired capacity
- If defined as lack of suitably accommodating housing options, then target resource scarcity (and deal with disabilities later)
- Quite different social investment strategies at issue – empirical research can help

# Pathways to Housing\*

- “Housing first” vs. “continuum of care” approaches to rehousing people from the street:



\* Tsemberis and Eisenberg 2000, *Psych. Services* 51(4)

# Circumlocution revisited

- Dilemma of street outreach in the 1980s – efficiency vs. engagement
  - Coercion: “gravely disabled” statutes
  - Arduous trust-building: PRO teams in Central Park
- The currency of *respect* (unearned & earned) reclaimed by a third way: provide housing first
- What *can* be done, even in imperfect systems