VIEWPOINT

Reimagining Institutionalization and a Continuum of Care for People Experiencing Homelessness and Mental Illness

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Editorial

Related article

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Current rates of suffering, abuse, neglect, and incarceration of those experiencing homelessness and mental illness represent an unacceptable humanitarian crisis. Political will to invest in solutions appears to be growing. New York City Mayor Eric Adams recently announced a plan to lower the threshold for involuntary commitment of people with mental illness living on the street. Portland Mayor Ted Wheeler declared similar intentions. In California, the newly enacted CARE (Community Assistance, Recovery, and Empowerment) Act intends to leverage courts to bring people with severe mental illness and substance use disorders into a system of care. Most recently, New York Governor Kathy Hochul pledged more than $1 billion for a comprehensive plan integrating hospitalization and community-based care. Although each proposal has prompted debate on ethical and practical grounds, this momentum provides an urgent opportunity to implement community-based care options, reimagine institutionalization, and finally build a functional continuum of care for those experiencing homelessness and mental illness.

These policies confront a staggering reality. Of more than 580 000 individuals in the US who experience homelessness on a single night, estimates suggest that more than half have a mental illness or substance use disorder and at least 1 in 5 have severe mental illness.[1-3] Limited mental health care for this population forces individuals into emergency departments, where they are frequently boarded or discharged to the street, generating high spending and dismal outcomes. Pandemic-induced closures of social services and psychiatric beds have exacerbated harm. People experiencing homelessness with mental illness face alarming rates of incarceration, discrimination, chronic disease, suicide, and premature death.[3,4] This is intolerable—and preventable.

A Brief History

To thoughtfully design the future, we must understand the pitfalls of the past. In the mid-19th century, in response to an analogous abundance of people with severe mental illness facing grim conditions in communities, almshouses, and prisons, reformers advocated for therapeutic institutionalization. Despite enormous state investment and ostensibly good intentions, rapid overcrowding reduced most asylums to carceral warehouses. Deinstitutionalization began in the mid-20th century, encouraged by patient advocacy, new medications, the development of the social safety net, and promises of federal funding for community-based care.

As legal rulings and financial strain accelerated closure of state mental hospitals, fledgling community-based programs were faced with a flood of hundreds of thousands of patients for which they were unprepared. Even programs that briefly thrived collapsed upon federal defunding of community-based care in the 1980s.[4] With simultaneous reduction in affordable housing and generic social services, the modern era of homelessness began. In the years since, continued underfunding of community-based care and further reductions in long-term inpatient capacity have left those experiencing homelessness and mental illness with nowhere to go. Today, city dwellers have grown accustomed to stepping around people living on the street.

Community-Based Care

Long-awaited commitments to fund a supportive and autonomy-promoting system of care are vital to end this era of deep societal neglect. The bedrock of this system must be homelessness prevention. Sustainable improvement needs policy that addresses upstream determinants of homelessness for those with mental illness, including increasing housing prices, income inequality, barriers to mental health care, racial inequities, and adverse childhood experiences. The 2022 Federal Strategic Plan to Prevent and End Homelessness delineates preventive strategies, including increasing access to community-based services and housing stabilization for those at risk. For example, Critical Time Intervention (CTI), a time-limited case management program, can reduce the risk of homelessness during transitions between hospitals, shelters, or jails and the community.

For those who become homeless, models such as the Boston Health Care for the Homeless Program demonstrate that proactive outreach by street medicine teams and shelter-based clinics can build trust—and ultimately care—among many individuals who are reasonably reluctant to seek services. Once connected, individuals can engage in integrated health care, day programs, peer support, and pathways to stable housing. Two specific community-based services that have evidence for reducing homelessness or improving outcomes for those with mental illness are Housing First, which provides immediate access to subsidized, supportive housing without precondition, and Assertive Community Treatment (ACT), which provides consistent, intensive support through multidisciplinary groups of professionals.[5] However, to date, inadequate investment, cost and regulatory barriers to construction, and stigma toward mental illness and homelessness have impeded their implementation.[6] Governor Hochul's plan offers promise: it devotes the majority of funding to supportive housing, CTI, ACT teams, and other pillars of community-based care.

Facility-Based Care Within a Continuum

Large-scale implementation of these community-based strategies is likely to provide mental health and housing stabilization for most individuals. However,

short-term hospitalization can be necessary for the humane care of those for whom the above options have failed and suffering persists. Decisions to hospitalize patients through involuntary commitment are complex and must be carefully considered, giving substantial weight to individual and societal risks of inadvertently forcing treatment on people whose decisions are their own. However, for patients whose psychiatric disorders are fundamentally impairing their decision-making ability and leading to severe harm, involuntary commitment does not sacrifice autonomy but may instead be considered compassionate and necessary to protect autonomy from debilitating illness. Thousands of unhoused people with severe mental illness are currently unable—as a symptom of their disorder—to seek and find help. Allowing illness-altered decisions to drive decades of undue suffering in streets and prisons is not justice. Pursuing involuntary commitment in the least coercive manner and for the minimum duration possible is critical. When coupled with investments in high-quality postdischarge care options in the community, involuntary hospitalization can allow individuals the dignity of opportunity to be treated for a treatable illness.

As in most fields of medicine, a small subgroup of patients with the most severe illness may need medium- or long-term inpatient care before they can recover. For these patients, overcorrection against institutionalization and a 95% reduction in state mental hospital beds have produced a dearth of publicly accessible, effective, long-term inpatient care options, contributing to poor outcomes.[4] We therefore support a limited rebuilding of public facility-based care capacity for people with severe mental illness, ideologically distinct from institutions of the past. Recognizing that this is historically fraught with failure, we propose 3 principles to guide the creation of new care models, which could fill a key niche in the continuum of care.

Principles of New Care Models

First, the design of these care models must recognize that purpose, meaningful relationships, and nourishing environments are fundamental to recovery.[4] Institutions modeled after traditional prisons and hospitals, which optimize safety by prioritizing isolation and oversight over community building, risk attacking mental illness while neglecting mental health. Alternative models may better facilitate recovery; for example, Worcester Recovery Center and Hospital in Massachusetts imitates a town, with small-group "houses," "neighborhoods," and a communal "downtown." Salutogenic design (eg, space for purposeful activities, nonconfining living spaces, sunlight) is associated with patient well-being and encourages recovery-oriented patient-institution relationships.[7] To help patients achieve meaning and purpose, staff can create daily opportunity for skill building, peer mentoring, and community formation.

Second, facility leaders must pay careful attention to the microculture they create. Many ills of asylums resulted from dehumanizing cultures that promoted custodial relationships with patients. Beyond modeling compassion and following trauma-informed principles, attending to culture includes ensuring that the needs of nurses, mental health workers, and other staff are valued. Riverview Psychiatric Center, a Maine state mental hospital, uses Schwartz Rounds, in which all staff and administrators collectively discuss patients and care challenges, to empower staff and reduce burnout. National implementation of objective and subjective quality assessments, patient and staff input, and substantive penalties to facilities for patient or staff abuse can promote healing cultures.

Third, compassionate inpatient facilities and community-based solutions are both key components, not mutual replacements, in an effective continuum of care. Community health care professionals rely on inpatient capacity for patients with severe mental illness, but to sustain gains made during inpatient care and avoid overcrowding, reintegration as soon as patients can thrive in the community is essential. Reliable reintegration requires a collaborative ecosystem in which institutions have established communicative partnerships with community programs to eliminate gaps that require patients to coordinate their care without support. Progress faces prominent obstacles, including health care professional shortages and insufficient funding. Yet, with innovation and state and federal investment, there is hope. The Homeless Outreach and Mobile Engagement program in Los Angeles, funded through California's Mental Health Services Act, is a successful example of dedication to active partnership across care settings—including crisis care, inpatient hospitalization, and housing—to ensure continuity.

Recent political momentum presents an opportunity to finally provide dignity, support, and humane care to those experiencing homelessness and mental illness. Informed by historical missteps, leaders should recognize that a continuum of preventive, community, and facility-based services is essential. People experiencing homelessness and mental illness have suffered for centuries. If health care professionals, patient advocates, and policy makers seize the moment and fight for investment in innovative and evidence-informed strategies, we may witness the dawn of a new era.

ARTICLE INFORMATION

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REFERENCES

1. HUD 2022 Continuum of Care homeless assistance programs homeless populations and subpopulations. US Dept of Housing and Urban Development. Accessed March 29, 2023. https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2022.pdf

2. Lebrun-Harris LA, Baggett TP, Jenkins DM, et al. Health status and health care experiences among homeless patients in federally supported health centers. *Health Serv Res*. 2013;48(3):992-1017.

3. Gutwinski S, Schreiter S, Deutscher K, Fazel S. The prevalence of mental disorders among homeless people in high-income countries. *PLoS Med*. 2021;18(8):e1003750.

4. Insel TR. *Healing: Our Path From Mental Illness to Mental Health*. Penguin Press; 2022.

5. Coldwell CM, Bender WS. The effectiveness of assertive community treatment for homeless populations with severe mental illness. *Am J Psychiatry*. 2007;164(3):393-399.

6. *Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*. National Academies Press; 2018. https://www.ncbi.nlm.nih.gov/books/NBK519603/

7. Weber C, Monero Flores V, Wheele TP, Miedema E, White EV. Patients' health & well-being in inpatient mental health-care facilities: a systematic review. *Front Psychiatry*. 2022;12:758039.