

THE HISTORY OF AMERICAN MENTAL HEALTHCARE
POLICIES AND AN EXAMINATION OF THE MENTAL
HEALTHCARE SYSTEM IN SOUTH BEND, INDIANA

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Mental illness is intricately related to social class, but it is difficult to understand exactly why and how the relationship continues and how to end the relationship. In their book “Social Class and Mental Illness,” Hollingshead and Redlich claim that “Americans prefer to avoid the two facts of life studied in [the] book: social class and mental illness” (3). In current American society, “ Growing numbers of mentally ill offenders strain correctional systems” (“Mentally Ill Persons in Corrections”). There is a link not only between the prevalence of mental illness and poverty, but also between low social class and the rates of discharge and reinstitutionalization among patients (Myers and Bean 82), as well as the types of treatment used and the place of treatment (Hollingshead 258). Focusing on the connection between mental illness and poverty could help improve the lives of those with mental illness who are poor, and their greater integration into society could improve the country as a whole.

This paper will examine the history of America’s mental healthcare system to understand how society’s views of mental illness have changed, along with the general approach toward treating mental illness. It will focus on patients who are economically disadvantaged. After a history of the laws and movements regarding mental healthcare in America, the paper will examine the mental healthcare system in a specific city: South Bend, Indiana. In doing so, hopefully more light will be shed on how the mental healthcare systems in America are successfully treating patients with mental illness and which patients are left either untreated or poorly treated. With South Bend’s system as an example to illustrate the abstract ideas of a mental healthcare system in a more concrete way, it is possible to gesture toward America as a whole from what is occurring within

the South Bend system. Ultimately, the issue is complicated and there are many questions, values, morals, and lives involved. For one, is the fact that so many patients are left untreated or not treated well a problem for the government to correct? Or should society in general feel remorse at the situation and assume the government should not take all of the responsibility for treating these people? Another important dilemma along these lines is how great of a financial burden the mental healthcare system puts on our society and how much financial matters are a part of decisions for the mentally ill. Essentially, there is never an unending stream of money to take care of people, so should the issue of mental illness be considered with no concern for spending or is there a necessary financial concern? While addressing the details and everyday realities of the system, this paper will also try to shed light on these greater abstract and moral questions.

The term “mentally ill” encompasses a range of people. The National Alliance on Mental Illness (NAMI) defines mental illness as “a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning” (“What is Mental Illness?”). The description continues to add that mental illnesses “often result in a diminished capacity for coping with the ordinary demands of life,” much like a physical disorder. In his article for the Washington Post, Harold Pollack differentiates between an “intellectual and developmental disability (I/DD)” such as cerebral palsy, Down syndrome, or an autism spectrum disorder (“Intellectual and Developmental Disabilities”), and a “serious mental illness,” such as schizophrenia, major depression, bipolar disorder, panic disorder, or borderline personality disorder (“What is Mental Illness?”). When people originally started differentiating from those with “mental illness” and those who simply acted outside of normal behavior definitions, society faced

the question of what to do with these people who either cannot at all or have difficulties taking care of themselves. Today, over a century after the first settlers in America started differentiating the “mentally ill” in their societies, Americans continue to grapple with what can be done to help those people who have difficulty taking care of themselves at times.

Hollingshead outlines the general societal thoughts about people who were mentally ill in his study of New Haven, Connecticut, entitled “Social Class and Mental Illness”. He explains that in the seventeenth century, people who were mentally “distraught” were taken care of by their family, brought to jail, or hung on suspicion of witchcraft (138). Toward the turn of the eighteenth century, the colonial communities adopted two customs, which continued into the nineteenth century. One was to “dump an insane person, usually in the dead of night, in another town to avoid caring for him at town expense” and the other was to sell the insane people at auction, after which the “bidder took his chattels to his farm, maintained them as cheaply as possible, and worked them as hard as he could in the hope of making a profit on the sick persons’ labor” (139). The state, then, viewed mentally ill people as a burden on the community and wrestled with how they could fit in properly without being an endless, unprofitable financial responsibility.

Around the beginning of the nineteenth century, most communities recognized the need for some other way of caring for the town’s mentally ill. Hollingsworth reports that the New Haven community established the first asylum for those called insane in 1822, which was chartered by the General Assembly. He claims the state hospital was viewed “from the day it was opened, as a dumping ground for chronic cases” and that many

physicians wanted to separate the chronically ill from the acutely ill into different hospitals to give the acutely ill a better chance of being “cured” (143). However, this was too gross a segregation for the public. Toward the early twentieth century, Clifford Beers founded the Mental Hygiene Society that aimed to improve the treatment and care of the mentally ill and was instrumental in the foundation of many psychiatric health clinics throughout the nation. Hollingsworth mentions that the first psychiatric clinic in New Haven was founded in 1913 (144). From here, the mental healthcare system continued to develop and new treatments, including Sigmund Freud’s psychoanalytic theory and other types of “organic” treatments like electroshock therapy and medicinal drugs, drastically changed the way people were treated for their mental illnesses (145).

In 1956 around 600,000 mentally ill people were housed in public mental institutions throughout the U.S. (Koyanagi 4). At the beginning of the 1960s, however, the system was drastically altered: the government recognized the inefficiency of the institution-based mental healthcare system and acted upon this recognition, with help from other forces pushing the system toward a change at that time—including the idea of liberation for the mentally ill. After World War II, for instance, Albert Deutsch’s exposé, *The Shame of the Streets*, exposed the dirty conditions and overcrowding in the state asylums, which outraged most of the public and encouraged the move toward deinstitutionalization (Torrey and Entsminger). Along with this, medicine advanced and in 1954 the first effect antipsychotic—Thorazine—was introduced and made it easier for patients with schizophrenia, who were often hospitalized, to control their symptoms and live on their own (Torrey and Entsminger). Primarily, however, the government focused on the financial burdens posed by the large state mental hospitals. Over a period of

twenty-five years starting in the early 1960s, the number of mentally ill in state hospitals dropped by three-quarters, falling to around 154,000, and through the next twenty-five years after that, many of the institutions were actually shut down (Torrey and Entsminger). Both the government and society promoted and acted upon the idea of “shifting the locus of control” from institution-based systems to systems of community services. The government believed the transformation would decrease mental healthcare funding and society believed it would allow people with mental illness to incorporate into the community and have greater independence (Koyanagi 4-5).

The problem, ultimately, was similar to the problem that the governments of early colonial times faced in the seventeenth century: how should people with mental illness be taken care of and, along with that, whose responsibility is it to help the mentally ill? Though, in the nineteenth century, mentally ill people were cared for in a much greater way than they were centuries before in the colonial time, the government was still concerned about how the care of this population would impact the individual communities and now even the nation as a whole. Particularly, the concern was financial, but the integration or failure to integrate the mentally ill into the community and the concerns of what to do with them in this way also have social, psychological, and cultural affects on the society. Humans, then, still grapple with what their role is in terms of taking care of those who cannot take care of themselves and maybe even lash out against society, disrupt it, or stand outside of it. How can people act morally—in helping those who are mentally ill—without significantly financially hindering themselves or without posing danger and discomfort to the community?

Thus, in thinking of the ways to integrate the mentally ill into society and provide them a richer life, but in also thinking of the financial burden that state institutions placed on the government, “deinstitutionalization” started across America in the early 1960s (Koyanagi 5). This moral and financial shift in thinking about the mentally ill saw its first actual affect in 1956, when the “reduction in the number of people institutionalized began” (Koyanagi 4). It did not accelerate into a “full-scale, nationwide policy” until the late 1960s and 1970s, however. The idea was to transfer the money that would have gone toward the state institutions and to move the people that would have been placed in institutions to community health centers. These centers, as described in a report by the Joint Commission on Mental Health entitled *Action for Mental Health*, were designed to “furnish prevention and early intervention services and to promote mental health”. In 1963, President John F. Kennedy also called for more comprehensive community programs to replace institutions and to provide “outpatient care, day treatment, rehabilitation, foster-home service, and public education on mental health” (Koyanagi 5). In response to these ideas, a federal program was created to build facilities that would become community mental health centers (CMHCs) in 1963. These facilities were required to provide inpatient, outpatient, and emergency care, partial hospitalization, and consultation and education on mental health (Koyanagi 5).

In 1965, Medicaid and Medicare were enacted. Because they allowed benefits only if the mentally ill patients were treated within specific standards (in certain facilities and by people with certain licensures) and, because the states and organizations that treated mentally ill people wanted to use these financial benefits, the mental health system was altered at this time. Medicaid and Medicare gave funding for patients to be

treated in nursing homes and clinics in general hospitals, rather than specialized psychiatric inpatient facilities. This fostered the movement of people out of a more long-term psychiatric hospital into a shorter-term general hospital, though the movement has also been criticized by some as a form of “transinstitutionalization” of patients from state psychiatric hospitals to nursing homes (Koyanagi 6). Ultimately, “though the thought was there” and there was a general “shifting the locus of care” from large institutions, where the mentally ill were held back from the potentially better lives they could be having in the community, there were major problems in the logistics and execution of the deinstitutionalization movement. Foremost, the resources were not present to execute the kind of plan that was imagined in order to make it successful and there were multiple streams of funding that were never coordinated into an efficient, direct outlet (Koyanagi 12). Harold Pollack explains that “even if hard measures actually were imposed and money actually saved, there was no automatic process, no obvious valve to turn, that would redirect these financial flows to community-based services provided by other agencies at other levels of government, to meet patients’ needs” (3).

It was clear, then, that some people were not receiving the same amount of care they would have received if mental hospitals had still been in place and in particular “many people who, in a previous era, would have been state hospital residents were not receiving adequate care” (Koyanagi 7). In recognition of this and to add on greater community supports, the National Institute of Mental Health created the Community Support Program (CSP) in 1975 to give grants for a greater range of mental health services and to help people with a serious mental illness live in the community. The program recognized other areas that needed to be addressed outside of clinical programs,

including housing, income support, food stamps, employment, transportation, and education (Koyanagi 7). Congress then amended the Community Mental Health Center program established in 1963, in order to focus greater attention on people with a mental illness and to “expand services beyond clinical care alone” (Koyanagi 7). This amendment was carried through via the Mental Health System Act.

The early 1980s saw struggles over government’s involvement in aiding the mentally ill through programs and services sponsored by state governments and the federal government; in this time, a conservative wave was rushing through the nation’s policy and the Reagan Administration in particular cut back federal supports of these systems. Koyanagi explains, “With no money, nowhere to live and an underfunded mental health service system, many were in dire straits”. However, toward the mid and later 1980s states made adjustments and benefits were given back to people with mental illness. In the 1990s, many of the large state institutions actually shut down, dropping from 300 to around 250. Finally, the Americans with Disabilities Act in 1990 and amendments made to the Fair Housing Act in 1988 expanded the legal rights of people with disabilities living in the community.

Financially speaking, Koyanagi reports that in 1993 “more state-controlled mental health dollars were allocated to community care than to the institutions” (9). By this time, the federal government mainly supported the public mental healthcare system through Medicaid funding, rather than through a funding stream or program (9). Koyanagi also says that the “recovery-oriented” mental healthcare system has been challenged in the last two decades and because of this a new system with a greater focus on “living a normal life despite having a serious mental illness” rather than total

remission of symptoms or cure is starting to take shape. This point will be deeply underscored by Lynn Rhody, a social worker at Epworth, later in the examination of the mental healthcare system in South Bend, Indiana.

Essentially, the deinstitutionalization method had both positive effects and negative effects. The treatment of mentally ill people is difficult because there are so many levels of mental illness, all with different effects and outcomes. Also, there is always the question of how integrated into the community people with mental illness should be, what their role in the community should be, what the community's role for the mentally ill should be, and who, ultimately, should be responsible for making sure the mentally ill are treated morally and live the best lives they can live.

Deinstitutionalization was started for many reasons and many of them were to better the lives of the mentally ill; good intentions do not always mean good outcomes, but there was a significant positive outcome for many of the mentally ill due to deinstitutionalization and community support increases after the 1960s (Pollack 2). However, the idea of institutionalization was not always thought entirely through and people who did not understand mental health and the needs of those who are mentally ill made many of the decisions. Pollack says, for instance, that "If you ask any social policy expert to describe a well-intentioned initiative that didn't work out as planned, the word 'deinstitutionalization' will probably appear in her response" (1). Torrey emphasizes this point in his review for the Treatment Advocacy Center, by saying that "Deinstitutionalization, the emptying of state mental hospitals, has been one of the most well-meaning but poorly planned social changes ever carried out in the United" (Torrey and Kennard 2).

Torrey and Kennard state there is “clear evidence that for many patients deinstitutionalization has been a disaster” (2). To understand this, it is necessary to understand the different types of mental illness that afflict people. Pollack does an exceptional job at explaining the difference between the mentally ill who have intellectual and developmental disabilities (I/DD) and the mentally ill who suffer from severe mental illness (SMI). Because people with an I/DD are generally better at living independently and taking care of themselves, Pollock explains that the community was more receptive to these people and therefore provided more funding to help them integrate into society more easily (1). These people were less likely to need a long-term, inpatient facility to help them through their mental illness, and thus were less affected by the closing of these facilities; their lives were less disrupted. Pollack explains that rather than “languishing in a backward of some state home,” those with an intellectual and developmental disability were able to be “more functional, much happier, and better off in virtually every way” by using community health centers and having greater liberty in their own lives (1). Pollack also goes on to explain that the community integration of people with an I/DD was not only a benefit to the people with mental disorders, but also benefitted the entire community by allowing people to befriend and spend time with the mentally ill who they might not otherwise have been able to. Pollock explains that:

Not long ago, people with intellectual disabilities were effectively barred from the public schools, workplaces, summer camps, and more...[they] were pushed to the margins. Segregation encouraged ignorance and fear. Few people had the personal experience to offset inaccurate or freakish media images of intellectual

disability. The cumulative movement of hundreds of thousands of people out of institutions into their own communities changed America (2).

So, in many ways, if these people could either take care of themselves or be taken care of by their families, they benefitted from the transformation of institutions to community mental health centers. However, there was another population that could not find the resources they needed at the community-health centers—mostly because they had a serious mental illness--and did not benefit from the shift to community programs.

The deinstitutionalization, then, had negative effects on both those mentally ill people and society who had to suffer the consequences of their improper treatment and grapple with what to do in order to help them appropriately. Primarily, those with serious mental illness (SMI), such as schizophrenia, major depressive disorder, obsessive-compulsive disorder, bipolar disorder, and affective personality disorder, suffered the most with the changing system. They were less accepted into communities—out of severe fear and misunderstanding by the communities—and also lacked the same kind of funding for services. Pollack says “it is much harder to attract required funds or public acceptance for best-practice SMI interventions” (3). He also claims “the intellectually disabled possess key advantages, while people with SMI were all-too-often released from inpatient facilities to communities and families that lacked effective supports to properly help them” (3). Essentially, the group that needed daily inpatient care the most—those with serious mental illness---are the ones who cannot take care of themselves with only a disconnected grouping of community support systems. These people often do not have the ability to understand how to incorporate the available systems and access them to their best ability. They may not be able to take their medications on their own without

the support of a daily caretaker. Pollock states, “downward trajectories are more common among individuals with SMI (particularly those with co-occurring substance use disorders) than they are among people with intellectual disabilities” (3). He continues to explain that:

Patients with schizophrenia or addiction disorders who require long-term residential services are served within an uneven patchwork of nursing homes and other inpatient settings, not to mention psychiatric emergency departments, jails and prisons (4).

The phrase “uneven patchwork” creates a particularly vital picture of those who are seriously mentally ill and require endless attention and support that cannot be attained through a transitory and complicated “patchwork” of treatment options. These people, as Kari Tarman—the Director of Communications at Oaklawn in South Bend—mentioned, often present to psychiatric facilities either from the emergency room or from prison. They do, either way, represent the “consequences of deinstitutionalization’s failures” to society at-large by occupying such extreme “treatment” facilities, if a prison and an emergency room can be reasonably called treatment facilities. Thus, it is clear that often times the severely mentally ill cannot mediate the appropriate treatment for themselves and because of this, get to a critically ill point at which they either do something violent or harmful in the community—and are put in prison—or somehow identify themselves as extremely “not right” and stand outside of the community—and are brought to the emergency room. These people often have painful and difficult lives. Because families are many times left to take care of the mentally ill after they have been taken out of an institution—as Koyanagi claims, “two-thirds of people discharged from the institutions

returned home” (13)—it rests upon the families to help the mentally ill people and to find the resources to do so. If there is no family, the mentally ill person must help him or herself. When dealing with someone with a severe mental illness, it is much more difficult and costly to treat the illness and often not only impossible for the severely mentally ill person to treat him or herself, but also for the family to help this person. In some cases, the person may not only be a financial and emotional burden but may also be dangerous and pose a threat to the family.

Ultimately, the severely mentally ill often become homeless. According to the Treatment Advocacy Center report, “A 2005 federal survey estimated that approximately 500,000 single men and women are homeless in the United States at any given time; multiple studies have reported that one-third of them are seriously mentally ill” (Torrey and Entsminger 11). So, although they are “caught” in the healthcare system at certain points—when they are most severely distraught and put into a prison or emergency care center—the severely mentally ill float in and out of this system. There is no “aftercare” when they are discharged from the system and thus it is likely they will not only become homeless again, but also enter the healthcare system again (Torrey and Entsminger 11). For these individuals, perhaps the only solution to homelessness--as they cannot support themselves and their families cannot support them—is a solid, consistent in-patient facility. Indeed, Torrey and Entsminger report “A recent study of 81 American cities demonstrated a direct relationship between having fewer psychiatric beds and more homeless individuals” (11).

Many of the chronically homeless, severely mentally ill people end up in prison. This is most likely because the severely mentally ill have trouble taking their medications

on their own, lack family support, and may have “bad judge of character” and thus not “hang around people who will guide them in the right direction” (Karman). They may also “self-medicate with alcohol and street-drugs,” increasing their tendency toward violent acts (Torrey and Kennard). Information on the percentage of mentally ill people in prisons is from the Treatment Advocacy Center report by Torrey and Kennard and is summarized in the following paragraph:

The most recent, and methodologically most impressive, survey of mental illness among jail inmates was published in 2009. A total of 822 inmates in five jails (three in New York and two in Maryland) were assessed using a structured diagnostic interview to determine the existence of serious mental illness during the previous month. Serious mental illness was defined as including schizophrenia, schizophrenia spectrum disorder, schizoaffective disorder, bipolar disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified. A total of 16.6 percent of the prisoners met criteria for one of these diagnoses in the previous month.

The publication by the Treatment Advocacy Center on the shortage of psychiatric hospital beds by Torrey and Entsminger also explains that there is not one county in the country that holds as many mentally ill in psychiatric facilities as there are mentally ill in the county jail. It also mentions that once a person is placed in jail, it is difficult to transfer them into a psychiatric facility. On average, it takes at least six months to find an available bed (Torrey and Entsminger 12-13).

Interestingly, the negative effects of deinstitutionalization are not only social and moral. They are not only that the severely mentally ill are made to “fend for themselves”

and live public lives of struggle, with a constant lack of care. It is not that the lack of proper care may actually allow the mental illness to take over the person and thus give them less liberty than they would have in an institution where their symptoms could be more controlled and they could live lives of greater choice and happiness, as some psychologists and researchers suggest. It is also not only that society has occasionally suffered from the anti-social, even dangerous acts of chronically homeless, severely mentally ill people on the street. Deinstitutionalization also had drastically negative economic effects on the nation. As described in the Treatment Advocacy Center report by Torrey and Entsminger, “Fiscal conservatives thought that they would save money by emptying state mental hospitals, but they in fact only shifted the fiscal burden from the department of mental health to departments of corrections and social services and to the courts,” (12) with a particularly strong example of one man: “In Reno a chronically homeless mentally ill man. . . cost the county at least \$1 million during his 10 years on the streets before he died in 2005,” (12). Essentially, while severely mentally ill patients go in and out of the system, they are never fully treated; this is a social, moral, and financial problem for the United States.

With a thorough review of the history of the mental healthcare system in America, from the creation of institutions to the deinstitutionalization process in the 1960s and after, this paper will now examine the interaction between social class and mental illness. It is helpful to examine where poor people fell in the system during the era of institutionalization, as there is more comprehensive and complete research on that past era: if social status affected type of treatment received, the place where the treatment was

received, the length of the treatment, or the effectiveness of the treatment. It is also interesting to compare the information obtained from that research to modern day interactions between social class and mental health. In that vein, this paper will outline the study published in 1957 by Hollingshead and Redlich—*Social Class and Mental Illness*--and the follow-up study conducted one decade later by Myers and Bean. This will give a comprehensive outline of the interaction between social class and mental health treatment during the time of institutionalization. Then, the paper will outline the South Bend, Indiana mental healthcare system and examine the interaction between social class and mental health treatment in this community. In general, there is lots of research on the effects of social class on mental health. Social class has been suggested to exaggerate or even cause mental health conditions, but mental health has also been suggested to lower a person's social class, mainly by decreasing a person's ability to work and function in society (Kohn 863). As seen in the previous history of the mental healthcare system in America, severe mental illness is often associated with the most destitute people of American society: those Americans who are homeless, in and out of the emergency room, imprisoned, addicted to drugs and alcohol, unemployed and unable to keep a job, or estranged from their families. Through examining the interaction between social class and mental healthcare treatment (including the quality of care and ability to receive care) and also in examining the general set-up of the mental healthcare system, some questions will hopefully be raised and considered, including: does society—through its mental healthcare system—allow those mentally ill in the lower social classes to be cured and live independent, healthy lives or is it much easier to do so in an upper class? Are many of the severely ill homeless on the streets or in prison from

lower social classes? Does having money allow someone with the same mental illness as a person in a lower class have fewer symptoms and live with the disease more successfully than the person with less money and, if so, how exactly? Does society stigmatize and fear people in a lower social class who are mentally ill more than people in a higher class, even if both have a similar illness? In that vein, is it harder for someone in a lower social class with a mental illness to integrate into the community with the mental illness—especially after some kind of treatment and discharge from a facility? This is a lofty set of questions, but there are many key facts that will help shed light on them within the studies of previous mental healthcare systems and current mental healthcare systems in America.

When they set out on their study in the early 1950s, Hollingshead and Redlich attempted to answer one broad question: “Does a mentally ill patient’s position in the status system affect how he or she is treated for his or her illness?” (1). During this investigation, they broke the question down into different components, including: does a patient’s social class affect the type of facility he is treated in, does the patient’s social status affect the type of therapy he receives for his illness, and does the patient’s social status affect the total expenditure amount for his treatment? In their decade follow-up study, Myers and Bean investigated if a patient’s social class was related to treatment status at the follow-up in 1960 (a decade after the initial research by Hollingshead and Redlich was conducted). They also investigated whether or not there were social class differences in the patients’ treatment, discharge, and readmission rates during the ten-year period and whether or not there were social class differences in the adjustment of former patients in the community.

Ultimately, both studies found that social class did significantly affect the dependent variables that they were testing throughout the list of questions above. Although in some contexts, the link between social class and the dependent variable was more obvious, there were general trends throughout all of the areas. In order to expound upon these trends, it is necessary to understand what Hollingshead and Redlich defined as “social class” and to understand the background and setting for their study.

Hollingshead and Redlich were working in one American community: New Haven, Connecticut. The community was founded in 1638 and the researchers point out that around eight to nine generations evolved on the land from then until the time of the study, with particular “periods” of time that divided the community’s development, including the Colonial Epoch, the Age of Industrialization and Immigration, and the Acculturation of the Immigrants (47). The data for the studies was drawn from the entire New Haven community, which the researchers call a “macroscopic approach” (12). Hollingshead and Redlich define “social class” through an Index of Social Position. The index uses a ranking system to define a final number to each person, which then places him or her into a certain social class. There are five social classes—with one being the highest social class and five being the lowest. The composite number for each person—which places them into a certain social class—is made up of numbers from three factors: address, occupation, and education. Address was given a factor weight of 6, occupation was given a factor weight of 9, and education was given a factor weight of 5. The “scale score” that each patient obtained via his or her address, occupation, and education was then multiplied by the particular factor’s “weight”. For instance, if a patient scored 4 for address, it was multiplied by 6 to give a total number of 24 which was then added with

the other two factors' numbers to get the patient's Index of Social Position Score and place them into a social class from one to five.

The first study compared social class to the psychiatric facility that the patient was treated in. There were five facilities included in the study: the State Hospital, the Private Hospital, the Veterans Hospital, public clinics, and private practice facilities. As many of the descriptions will be helpful in detailing the mental healthcare facilities in South Bend—taking into account the transformation of certain areas of the facilities during the past few decades however, they will be explained in more detail here in regards to how they were defined in the Hollingshead study. The chronic wards in the 1950s survey of Concord are described as dark and unsanitary, whereas the state acute wards are described as “more hospital-like; a definite effort is made to study and treat each patient's problems that he may be released and not add to the seriously overpopulated chronic wards” (147). In the 1950s, the state hospital was used to treat new cases and to care for chronic cases. If the patients needed to stay longer than thirty days, they were “committed” to the hospital by a Probate Court with statements from two physicians in the state hospital. Although veteran hospitals were similar, Hollingshead remarks they were “newer, and maintained according to higher standards [than state hospitals]” and that they were “well run, active in their therapeutic program, and interested in research” (150). The private hospitals were less common in communities than state hospitals and in the Concord area that Hollingshead and Redlich based their research, there was only one. They explain “their accommodations range from luxurious cottages on carefully landscaped country estates to dismal decaying old mansions that are almost as poorly maintained as the state hospital” (150). The cost of staying in one of the

most exclusive “hotel-like” private facilities along with therapy and personal services was around \$20,000 per year in the 1950s—about \$200,000 per year today--whereas the less expensive private hospital were closer to \$7,000 per year in the 1950s. Hollingshead goes on to elaborate the difference between state and private hospitals in the 1950s in a key paragraph:

The aims of private hospitals are identical with those of public hospitals: to cure or to care for patients. Beyond their avowed general purposes, public and private institutions have little in common. The responsibility of the private hospital ceases when the patient or his family is unable to pay the bill. After a patient’s financial resources are exhausted, in practically all cases he is either discharged or transferred to a public hospital. “Pay or get out” is the rule. (151)

Similar to the system in South Bend, which will be elaborated in greater detail later, the private hospitals in the 1950s had a much higher ratio of employees to patients than the state hospitals (151). Accordingly, the lack of resources in the state hospitals and now in the community mental health centers and centers that take all patients, like Epworth and Oaklawn in South Bend—financial and staff-wise--limit the treatment that each patient can receive in the state hospital and community centers. Public clinics, which are much more popular in present day after deinstitutionalization and replaced a number of the state hospitals, are often in great numbers in cities and can each specialize in different kinds of treatment. Hollingshead and Redlich noted that “emphasis on the importance of clinics is growing” in the 1950s and it has certainly continued to do so. Private clinics have also grown in number since the 1950s.

Hollingshead and Redlich, with the idea of five distinct facilities for mental

illness, researched where patients were treated based on their socioeconomic status, with the status calculated as previously explained. They found that one of the strongest determining factors for treatment facility was diagnoses of either neurotic or psychotic disorders. Whereas eighty-seven percent of neurotics were treated solely on an ambulatory basis, ninety-one percent of psychotics were hospitalized during their illness (258). They explain earlier in the book “incidence for the neuroses is not linked to class,” but the rates for re-entry into treatment and prevalence of neurotic illness are “related significantly to class status” (235). They also explain that in psychotic disorders, the incidence is almost three times greater in people of class five in comparison with people of class one and two and that the incidence in class five is double the rate for class four incidence. In general, they found that a higher percentage of psychotics are hospitalized whereas a higher percentage of neurotics are treated in outpatient facilities (276). They also analyzed the specific breakdown of psychotic patients, their socioeconomic group (from numbers one through five), and the type of psychiatric agency they were treated at. The results indicated that in the 1950s, 89 percent of class five psychotic patients were treated in a state hospital and 6.8 percent in a public clinic, whereas 67 percent of combined class one and two patients were treated in a private hospital and 23 percent at a private practitioner. That leaves 9.6 percent treated in a public facility (a public clinic or state hospital) for the combined class one and two patients, whereas 95.8 percent of class five patients were treated at a public rather than private facility (276).

They discovered that many times along with different treatment facilities, people of different socioeconomic classes receive different types of treatment. They examined the principal type of therapy received by people of different class groups. One study

analyzed the type of therapy received by patients with schizophrenia in state hospitals. They conclude, "Only a small proportion of the schizophrenic patients receive psychotherapy but the class one to two patients receive it twice as frequently as the class five patient" (292). They stress that, although "custodial care is prescribed for the highest proportion of the cases in classes one through two and in class five," (293) the number of class five patients in the first and second class in the state hospital is very low and the patients have been ill for a long time, with numerous previous hospitalizations. Thus, those patients in class one or two receiving custodial care in the state hospital are truly "burned out" and at the "end of the road" (293). Psychoanalysis is an expensive form of treatment, whereas organic therapy (like drugs or some other form of brain technology) is not as expensive or time-consuming and custodial care is a kind of "giving up" on the patient's chance at a successful improvement. The different types of treatment and facilities connect with social class and likely with the patients' source of payment. In private agencies, 95.7 percent of class one to two patients paid for treatment either on their own or with help from their family, and almost zero percent of patients in class five paid for treatment on their own or with help from their family, while 70 percent paid with some kind of veterans administration help. In terms of public agencies, the town and state paid for 21.3 percent of class one to two patients, whereas town and state paid for 68.7 percent of class five patients (313).

Essentially, patients who have their own money (either from their own income or from family resources) can choose where they want to be treated and how they want to be treated in a much greater way than patients who have to rely on the state or the town to pay for them. Because the state hospitals and clinics were often understaffed and did not

have the resources to provide as focused and attentive care as many of the private facilities, the poor who could only afford the state hospital and clinics were often not treated as well and did not always receive the best type of therapy for their illness, as they normally received the cheapest type of therapy. Although the mental healthcare system is different today, there is still a similar distinction between private and public facilities and a similar division of use based on the money that patients have.

Myers and Bean expanded on the study by Hollingshead and Redlich by researching the state of the patients after one decade: in the 1960s. Their results speak to the prejudices of hospital staff; specifically, how socioeconomic status affects the way the patients' socioeconomic statuses affect the staff's opinions of the patients and the way that the patients are treated in the hospital. Essentially, this goes beyond the purely financial explanation for why there are different treatment types amongst patients or different lengths of stay. Myers and Bean observe that "type of treatment is strongly related to initial discharge rates; 53 percent of persons receiving psychotherapy or somatotherapy but only 11 percent of those receiving drug therapy or custodial care were release initially from the hospital" and that "social class is related to principal type of therapy: the higher the class, the greater the percentage receiving psychotherapy or somatotherapy" (97). Discharge, which is assessed based on the improvement of the patient, is normally determined by the attending psychiatrist and thus should be based on the improvement of the patient; if wealthier patients are connected with different therapies and different facilities, there could be an unwarranted thought that wealthier patients are in general more able and ready to be released.

The mental healthcare system in South Bend serves as an example of the changes that have taken place in many different cities around the United States and the effects of these changes. Since the 1960s and deinstitutionalization, the mental healthcare system has received varying levels of funding. Lynn Rhody—the manager of social work at Epworth Inpatient Hospital—says that the funding was more “free flowing” in the 1980s, while since then it has really dried up for communities such as South Bend. When the push was large to transfer most of the in-patient and long-term care options into more short-term, community care options, there was funding for a plethora of different outpatient services, while now patients are encouraged to get out of the system quickly, and so these many funding sources have lessened. Rhody specifically cites the Recovery Act, which she says called for many good things, but also many bad changes.

Rhody says that compared to the 1980s, enthusiasm and funding has decreased for the transformation of in-patient facilities to community mental health facilities, and that has affected the healthcare system in South Bend. To start, she mentions that mental healthcare treatment is not usually a profitable business. In order to treat everyone, just like in general healthcare, there are going to be costs put on the system that cannot be paid by the patients who do not have money to pay for their treatment. With mental healthcare in particular, those who are seriously mentally ill often cannot maintain a paying job and so must rely either on their former savings, families, some kind of commercial insurance or government program, or they must get treatment without having any way of paying for it. Rhody claims these patients come back to the psychiatric facilities often and require a lot of resources; although it is to the patient’s obvious

benefit and the benefit of the community that these patients are treated and can assume their normal, healthy lifestyle, mental healthcare facilities are “businesses”. They get little help from the government after the 1980s, although they see a lot of pressure from governmental agencies that demand efficiency and better care. Rhody emphasizes that if the mental healthcare facilities—especially the facilities that receive government funding and focus on treating patients with Medicaid, Medicare, or no insurance—did not have an intelligent fiscal plan, they would not be able to stay in business and so would not be able to help anyone in the community. So, even if some of the patients are not getting fully treated, it is not only the fault of those working at facilities or therapists in town; the system as a whole has never been fully examined and fleshed out. Many of the changes made may not have the effects intended because people who do not understand the system well enacted them. Healthcare facilities often work with the resources that they are given to provide the best care possible for people in the community. However, there are many issues because of the lack of funding and the unorganized structure of the mental healthcare system in South Bend.

Because of this lack of funding and organization, The Madison Center—a large outpatient and inpatient psychiatric facility--shut down in 2010. The Madison Center, explained by Rhody, was established around sixty years before it shut down and was located near the current psychiatric facilities Oaklawn and Epworth. Rhody says it more or less “imploded” as funding was cut after the 1980s. When this happened, the Madison Center had to pay their employees less and they could provide less care for patients. Psychiatrists and other staff started to leave and the formerly committed team and then fewer staff members had to do a great amount of work, which decreased morale and

quality of care. Eventually, locum tenens psychiatrists were hired to take the place of the former psychiatrists who left. Locum tenens psychiatrists travel around from facility to facility and do not get to know a community as well as a psychiatrist who stays with the company for longer than a few months. Because of this, the patients often had new psychiatrists, which is not, as Rhody says, good care. Finally in 2010 because of financial reasons, The Madison Center closed. An article from Eyewitness News, an Indiana newspaper, further elaborates on the closure: “Bondholders petitioned to have the Madison Center placed in receivership because it owed more than \$50 million borrowed for capital projects” (“South Bend Hospital Buys Madison Center Buildings”).

Memorial Hospital had an inpatient psychiatric wing in its main hospital in the late 1900s, Rhody says, and so understood the importance of providing psychiatric care for the community. With the closing of the Madison Center, there was a major lack of care for the mentally ill in South Bend. The Madison Center had a large outpatient service and around 90 inpatient beds in their inpatient unit (“Memorial Hospital of South Bend to Purchase Inpatient Assets of Madison Center”). In an effort to provide mental healthcare for people in the community, Memorial Hospital established Epworth, an inpatient psychiatric hospital. To compensate for the loss of the outpatient component of the Madison Center, a psychiatric facility in Elkhart—Oaklawn—opened up outpatient facilities next to the Epworth Hospital. The shift was challenging not only because the staff and facilities were transformed, but also because the Madison Center was essentially divided into two different parts; rather than integrating the outpatient and inpatient facilities into one center, they were divided into two separate centers. While the staff at Oaklawn that works with the former inpatients of Epworth do interact quite closely with

the staff at Epworth and understand what exactly Epworth does and who they help, there is still a much greater disconnect between Oaklawn and Epworth than there was when the two components of care were in the same building and handled by the same company (Rhody).

Oaklawn and Epworth are two main components of the mental healthcare system in South Bend, as they replaced the largest center—the Madison Center--and handle a large number of patients. However, the system is broken down into many different agencies. Essentially, Oaklawn and Epworth handle a bulk of the very ill in society; they see all patients who need their care, including those who have Medicaid, Medicare, or no insurance. There is also a bulk of psychiatrists and therapists who only accept commercial insurance or private payment. These are community therapists and psychiatrists with their own private clinics who are not equipped like Oaklawn and Epworth to handle the seriously mentally ill. These community providers mainly focus on what Rhody calls the “worried well”: those who are mentally distressed to a certain degree, but are not in risk of being acutely distressed or in need of comprehensive community supports and inpatient care. Their diseases affect them, but they are not as debilitating as those who have serious cases of Schizophrenia, bipolar disorder, personality disorders, and a number of other serious mental illnesses. An example of one of these providers is Wellness Associates, which is run by a counseling psychologist who is certified in psychotherapy and other mental healthcare treatments including brainwave optimization. The clinic is described as wanting to “strengthen positive relationship skills and release the patterns that have become problematic” in their patients and they offer help to people experiencing “depression, anxiety, low self-esteem or other distress”

("Wellness Associates Information"). This is largely accomplished through some type or a combination of therapy sessions, including individual, group, couples, or family.

The divide between serious mental illness and the "worried well" is not so straightforward as Epworth and Oaklawn versus the private practices in South Bend. There are a number of clinics associated with Memorial and St. Joe's that handle some of the psychiatric issues of patients who come in, whether it be in actually providing medication or in doing kinds of family or group counseling. The Memorial Hospital clinics include the Center for the Homeless Clinic (which is attached to The Center for the Homeless, but associated with Memorial Hospital), the Memorial Medical Group Behavior Health outpatient mental health practice, and the E. Blair Warner Family Medicine Center, which includes services like individual and family counseling and a social concerns educator and social worker. The VA Northern Indiana Health Care System provides mental health services, including medication management and individual and group counseling, for veterans in South Bend and the surrounding area as well. It is a community-based outpatient center ("VA Northern Indiana Health Care System"). In certain scenarios, these clinics can be enough to help patients and can provide the care for patients who do not have the ability to see private therapists or who have a more serious mental illness than what a private therapist can handle on his or her own.

In large part, then, Epworth handles cases of acute mental illness, where the mentally ill person must be retained for around five to seven days in an inpatient hospital. A seriously mental ill person goes through cycles, Rhody explains, and will sometimes be at a higher level of distress than at other times. When they go through a period of high

distress, they may be a danger to themselves or others and are then admitted for care at Epworth until their symptoms lessen and they are not in such a high level of distress. Once this happens, they can receive outpatient care at Oaklawn or another facility. Oaklawn is committed to treating people of lower socioeconomic status, while Epworth treats anyone who is acutely mentally ill--whether they are of low or high socioeconomic status. Thus, Epworth has a range of patients, as mental illness is not only environmentally influenced, but also biologically influenced. Although low socioeconomic status is associated with the development of serious mental illness and serious mental illness can cause people to lose their jobs and enter into low socioeconomic positions, Epworth does not only see low socioeconomic patients with severe mental illness. Rhody says they treat businessmen, homeless people, Notre Dame students and professors, bankers and other varieties of people. As will be discussed further, this connects not only with Oaklawn's mission, but also hints at the shortage of services Oaklawn can offer. Patients with commercial insurance or who can pay for their own care must go to another community therapist and most of these only accept patients who have commercial insurance or can pay out-of-pocket: not patients with Medicaid and Medicare. The other small outpatient clinics provide different amounts of medical support, though most of these clinics, like the Center for the Homeless Clinic, do not have mental health specialists, but rather general physicians. If they do have mental health specialists, they most likely cannot provide the same comprehensive care that Oaklawn or Epworth could provide.

The inpatient facility Epworth has many different units, including the acute adult, geropsych, adolescent, and depression. As stated before, patients must be at a certain

level of acute distress before they are admitted into Epworth. Once they are admitted, the hospital tries to lower their distress and to release them in a period of five to seven days. The psychiatrists who work at the hospital are in charge of monitoring the patients and deciding when they are ready to leave the hospital. Rhody stressed that even if the patients would still be termed “not okay” by the general population and medical professionals, once they have crossed the threshold from acute distress to less than acute distress, they must be discharged, even if they are still in some distress. This is because the beds at Epworth are in high demand and it is expensive to keep patients in the hospital. Epworth is also a non-profit organization, but they rely heavily on insurance payments and grants in order to finance the services they provide. Rhody says that if a patient comes in, the staff at Epworth calls their insurance company to ask how many days the company will pay for the patient’s treatment. Usually the insurance company gives two to three days, she says. At that point, the psychiatrist evaluates whether or not the patient is below the “threshold” level that would require their admission into or continued stay at Epworth. If they are below that level, the patient is released, but if they are not, Epworth staff calls the insurance company again to ask for continued stay. Occasionally the company complies, but often it does not, says Rhody. Even if the company will not pay for another day of treatment, if the psychiatrists do not believe the patient is safe to be released, they will not admit the patient and pay for the extra treatment. If the staff believed the patient should stay for a number of extra days, the psychiatrist from Epworth could meet with one of the insurance company’s doctors and show their case for the patient’s continued stay. After this, the insurance company may agree to pay for the extended stay.

Rhody says that if Epworth cannot provide the care the patient needs—mainly, if the patient needs to stay longer than around sixty days (although the staff would try to get them out much sooner before then), the “final” option is the state hospital. This is if the patient really cannot get stabilized and is not safe going to a group home or another outpatient support service. Between Elkhart and St. Joe counties, there are a total of twenty-six beds available in state hospitals for the seriously mentally ill who cannot get stabilized. Although Rhody claims that this option used to be highly beneficial for the patients who went there, as they really needed the intensive, long-term treatment, now state hospitals have received such pressure to cut down the amount of time they treat patients that a patient could spend the same amount of time or even less in the state hospital than at Epworth. Thus, the staff at Epworth occasionally sees patients they sent to the state hospital two or three months before turn up in the emergency room or on the streets and back in the wards at Epworth. The former way that these severely mentally ill people could be most effectively treated no longer works as effectively, then, after the state transferred the locus of care from longer, inpatient treatment to shorter, outpatient treatment. The number of beds in the state hospital has been decreasing each year, as the inpatient wards receive less and less funding from the state governments, says Rhody. Rhody also explains that the hospitals in the state that patients can go to (state hospitals with an inpatient ward) include Richmond, Madison, Evansville, Carter, and Logansport Hospital. The closest facility—Logansport—only takes forensic cases, however, and so none of the severely mentally ill patients from Epworth go to the Logansport Hospital. The other hospitals can be up to a few hours away, which is incredibly difficult and frustrating for family members of the patient. The state hospitals, because beds are so

limited, are incredibly difficult to get Epworth patients into. When one of the twenty-six patients leaves, another can come: thus patients can wait several weeks to get into the state hospitals. This number is for Indiana, whereas other states such as Michigan have a waiting time of only a few days, while still other states have a longer waiting time.

Rhody also comments that the patient leaving the state hospital goes into a group home and then takes away a spot from another patient in another short-term facility or a patient on the street looking for affordable housing and support.

Once a patient is stable enough to leave Epworth, they are scheduled for an outpatient appointment at another facility like Oaklawn. In ideal circumstances, this appointment takes place within seven days after the patient's release from Epworth. Many patients are scheduled for appointments at Oaklawn—the designated community mental health center in St. Joe County and therefore one of the most comprehensive outpatient programs in South Bend. Rhody comments that after Madison split into the two facilities—Epworth and Oaklawn—it is more difficult to “flow” patients from one facility to the other. She said that Oaklawn is often busy and sometimes the doctors do not understand the point the patient was at when she or he left Epworth or how to correctly continue the care. For example, she cites a case about a man who requires an intravenous injection every month in order to control his psychiatric symptoms. After he was released from Epworth, the staff tried to set up a new patient appointment for him at Oaklawn. Oaklawn was busy during the month though and continuously delayed the appointment. The staff at Epworth was worried that a month would elapse before the man could have his new patient appointment and get registered for another appointment to receive the injection. If he did not receive the injection, he would most likely relapse

and suffer severe symptoms again. Although some of the staff at Oaklawn assumed Epworth could simply administer the shot to the patient, Rhody explains that they could not because he had been discharged from Epworth and was no longer their patient. In order to be a patient and receive treatment from Epworth, you must be at the threshold level of acute illness and be an admitted inpatient; it is, ultimately, an inpatient facility and so does not provide the kind of follow-up or monthly procedures like an outpatient facility would. As these two important facilities are relatively new and still learning to work together, problems like this will most likely continue to occur.

Oaklawn provides many different outpatient services. It was founded by Mennonites in 1963 and was originally in Elkhart County. In January of 2010, after the Madison Center closed, another chapter opened in St. Joe County. Kari Tarman, the Marketing and Communications Director at Oaklawn, explains that it is the designated Community Mental Health Center in St. Joseph County. This means that the center really cannot turn anyone away who comes seeking mental healthcare. They accept people with Medicare, Medicaid, and no insurance, and as Lynn Rhody mentioned they prioritize these people, because a patient on Medicaid or Medicare would not be eligible for many private services. They also work on a sliding fee scale, and so they charge different amounts based on the financial situation of their patients. They use almost five million dollars each year in “charity care” for people who cannot afford any or some of their mental healthcare. The center provides a comprehensive rehabilitation plan: a “plan of care”. They are able to provide more services to help the seriously mentally ill integrate into the community than other companies can, especially because as the designated county community mental health center they receive greater funding to do so. Rhody

pointed out, however, that with the Recovery Act recently instituted, there is a greater focus on treating the current symptoms and problems of someone with a mental illness and less of a focus on treating the patient in a sustainable way: in helping them remain healthy for a longer period of time than simply the few weeks after they have been quickly treated. Rhody explains that people with serious mental illness—a mental illness that is more or less chronic—go through cycles. They have good moments, but they also have bad lows and it is necessary to know when they are having a time of acute distress in order to help them before they end up in the emergency room, prison, or some other place.

The Recovery Act does not trace patients for long periods of time or provide a constant presence and assessment. Instead, it focuses on “self-empowering” the patient and giving them liberty in their own life: thus in treating the patient for their symptoms and letting them live independently after they are treated. It encourages, in a sense, the least invasive form of intervention. However, this means that people with serious mental illness will come back to Epworth—the inpatient hospital—multiple times a year when they go through a period of acute distress. Rhody stresses that if Oaklawn could provide more long-term and comprehensive support for patients, patients would have fewer phases of acute distress. People helping them would be able to note the phase coming and try to prevent it or at least to put them in the hospital before they ended up somewhere worse.

Kari Tarman from Oaklawn notes that medication management is a large struggle with outpatient practice. As the patients are not constantly monitored, they do not always correctly take their medications and then end up with symptoms and possibly in an acute

distress phase of the illness. Oaklawn does provide 108 total beds in “transitional housing” sites, which allow the patients to live semi-independently. Nurses visit them in their homes, along with skills trainers and care facilitators. They are able to practice basic life skills, like cooking and cleaning, while having the support of the Oaklawn staff. This, says Tarman, is often the stabilizing influence that someone with chronic illness needs. The facility only allows for 108 patients to take advantage of this set-up, however, because of funding limitations.

Money-wise, Oaklawn is a non-profit organization. Tarman says that they receive special funding from the government for being the designated Community Mental Health Center in the St. Joseph County region. Along with this, however, Tarman says that the Oaklawn staff is aware that Oaklawn is not only a charitable organization, but a business as well. Thus, they are very frugal. Although they focus on treating people in low socioeconomic classes, specifically those with Medicaid, Medicare, or no insurance, they always require the patient to pay at least a small portion of their healthcare fees. Depending on the patient, this could be as low as five or ten dollars. Tarman says this also encourages patients to learn money-management skills. Tarman emphasizes that Oaklawn works hard to find funding and grant money to pay for more physicians at the facility and they are very frugal in the kinds of publications and events they produce, along with their day-to-day workings. Finally, in order to actually use the governmental funding, there are certain mandates that Oaklawn has to follow. For instance, in order to get Medicaid benefits, Oaklawn has to treat a patient enrolled in Medicaid with a certain type of psychiatrist or therapist. The therapists must be licensed MSW's or LCSW's in order to benefit from the Medicaid funding. Tarman notes that it can be difficult to

inform people—like those interested in going into social work or therapy--of these rules and each state has its own unique requirements for Medicaid and Medicare usage, which complicates the matter as well.

Apart from Oaklawn and Epworth, there are a number of other outpatient centers that treat mental illness to different degrees and there is a sector of private psychiatrists and therapists as well. Starting with the outpatient centers associated with the hospitals in South Bend, the list includes Memorial Group Neighborhood Health Centers. Dr. Zabukovic is the medical director for the Memorial Neighborhood Health Centers and sees patients at the Central Clinic of the Center for the Homeless and at Centennial Clinic attached to Memorial Hospital. He is also the medical director of Olive Street Health Centers—which is a title x clinic where women can go for sexually transmitted disease testing and contraception. Through his work at the many neighborhood centers, he sees people with mental illness from all over the region. He says that if “garden variety” mental illness is included—what Lynn Rhody calls the “worried well”—that around 30-50% of his patients have some kind of mental illness. The “garden variety,” for example, would include mild to moderate cases of depression and anxiety. Dr. Zabukovic says that although he sees many patients with mental illness, it does not necessarily mean that all of them must be referred onto more comprehensive, psychiatric-focused centers like Oaklawn and Epworth. Rather, he says that the centers he works at can actually effectively treat many of his patients’ psychiatric illnesses without requiring any outside support. This is because Dr. Zabukovic has the knowledge and ability to acquire prescription medication. Other primary care offices, he notes, would not be able to treat patients’ psychiatric illnesses to the extent that the offices he works at are able to. The

Memorial Neighborhood Health Clinics are associated with Memorial Hospital and specialize in intensely treating the patients that come in—almost in a way that the Hospital itself would be able to—and thus can provide more than just check-ups like in other primary care offices, but also minor procedures, well-woman check-ups, and other specialized services. It follows, then, that they would be able to provide greater psychiatric care. He says specifically, that they “pretty comfortable treat most depression and anxiety, but also manage schizophrenia and bipolar disorder.”

Dr. Zabukovic says that he absolutely sees a correlation between a patient’s socioeconomic status and the incidence of psychiatric illness. He also says that the type of psychiatric illness often correlates with socioeconomic status. The incidence of illness increases as socioeconomic class lowers and in lower socioeconomic classes, major mood disorders and psychotic disorders are more common. Major mood disorders include severe forms of depression, anxiety, and bipolar disorder. Psychotic disorders include schizophrenia. He also says that addiction problems are more common in the poor, especially because it is an easy choice to release stress about the psychiatric illness and there is not as much support and education to help poor patients end their addictions. Dr. Zabukovic says that many patients rely on just the clinic that they are visiting him at—such as the Center for the Homeless Clinic (attached to the Center for the Homeless)—to fully manage and treat their psychiatric illness. He says that this is usually based on insurance (or lack thereof) and the lack of capacity for psychiatric services in the St. Joseph County region. Thus, many of his patients are limited in their ability to receive certain types of psychiatric treatment because of their income level.

Dr. Zabukovic elaborates on that point to explain that he refers many of his

patients, if they need additional help managing their mental illness, to Oaklawn (for outpatient psychiatric care) or to Epworth (for inpatient services). He says that the poor patients and wealthier patients in South Bend would not theoretically receive different kinds of treatment, but that they would most likely receive treatment at different places for certain illnesses. He explains that people with insurance and ample money “tend to have private psychiatry and counseling, whereas the poor have to go to Oaklawn.” Oaklawn is in a sense “tailored toward” the poor as the designated Community Mental Health Center in St. Joseph County and works toward giving people who cannot pay for healthcare at any other facility psychiatric care.

Although this connects with Redlich and Hollinghead’s findings that people in lower socioeconomic classes are treated at different facilities than people in higher classes, this does not necessarily have the same meaning as the “state institution” versus “private hospital” division that they found. Oaklawn provides comprehensive services for its patients; it is not the “bad” facility that does not treat its patients as well as the private, “better” facility. However, Oaklawn is more limited in its ability to treat patients than the numerous private practices, like the Wellness Associates, because it sees all of the patients who need help paying for their care. They have a shortage of resources, whereas the private practices are not required by the state to take care of a huge population and so can manage their resources to make sure quality care is provided to all of their patients and that the facility and staff are not over-extended. Dr. Zabukovic also points out that the poor patients “have to go” to Oaklawn. Although Oaklawn provides comprehensive care and so patients would not necessarily be upset to go there, the fact that they have no other choice points out how limiting their incomes are. Whereas people

with higher incomes can choose how to manage their own illness and which facility they like best, people of lower incomes are “shut out,” essentially, by some facilities that require private insurance or out-of-pocket payment.

Essentially, that is what Rhody, Tarman, and Zabukovic all point to in order to improve the mental healthcare system in South Bend. Rhody explains that there is a general movement in the realm of healthcare—not only psychiatric healthcare—to shift the locus of care from long-term, inpatient services, to shorter and more focused treatment. There is a movement to provide better prevention to keep people out of healthcare facilities and to treat the patient’s illness as quickly as possible so that they are able to leave the facility and enter the community again. While Rhody commends the idea of integration and the liberty that this provides for patients, she says that this idea only really works for and helps a certain population. There are other populations, like those who need a comprehensive, long-term plan in place, that do not benefit from the decreased funding and thus the stress falls on the businesses providing healthcare for the mentally ill. The Madison Center stands as an example of what can happen to a business that tried and could not afford to treat all of its patients fully with a huge lack of government funding to help it do so. Rhody, Tarman, and Zabukovic all comment that South Bend needs to have more psychiatrists, therapists, and mental healthcare workers in general. They also agree that there needs to be a greater number of these healthcare workers—doctors, therapists, social workers, and so on—who will accept Medicaid or do a sliding scale payment, rather than allowing Oaklawn and Epworth to realize the need for this in the community and act upon it. They say if the stress were divided amongst more facilities it would help the community treat the mentally ill—especially the large

number of poor mentally ill--much better. It would also, touching upon the Hollingshead and Myers studies, allow the poor to have more time in care and to have more options about where to go and what type of treatment to get. This would mean that the poor in South Bend do not have to rely only on Oaklawn, Epworth, or whatever mixture of outpatient and primary care services they could find, but could also use many of the private facilities which are not as understaffed and lacking in resources. If each private facility helped to treat a certain percentage of the poor, the problem would fall much less on one organization; relying on one or two organizations can lead to burn-out and failure, as in the Madison Center, no matter how well they finance or manage the business side of the organization. Rhody also comments that there should be a greater focus from the funding end on comprehensive care, making note of the different kinds of care necessary for people with varying degrees of mental illness, rather than a pure focus on simply curing the presenting problem as quickly as possible and then dismissing the problem. She says this would allow for people who have serious mental illnesses to have less serious episodes and end up in the emergency rooms or in prison less frequently.

Mental healthcare is complicated and it has evolved mainly in the last century. Thus, the healthcare system is still growing into itself. It has had multiple pushes from the society and from people who do not really understand mental illness—like lawyers and politicians. Because of this, the system has suffered and “deinstitutionalization” has become one of the notorious policy failures. There are many people working within the system who are frustrated by it and many people who suffer at the hands of it, especially the poor, seriously mentally ill. However, there are many aspects that show the potential of the transformation: that America know, in a much more real sense, the mentally ill and

is able to see the people who need funding for mental healthcare treatment, for instance, rather than keep them inside of an institution. Although this comes with all of the negative effects outlined in this paper, an issue so complex will not quickly and easily slid into a perfect solution. In order to treat the people who truly suffer—the poor, severely mentally ill—and give them the kind of life they would bring them happiness, society must first decide if they would rather take up that burden or leave them to handle their lives on their own. Those in mental healthcare—Rhody, Tarman, and Zabukovic—and who work with the mentally ill everyday all advocate for them. Rhody says that she has met amazing people going through difficult circumstances who are unfairly and harshly judged by society and even their own families. All three suggest that the community does decide to take up the call to help and that to do this, there must be greater funding and more mental healthcare facilities who will help treat those who cannot afford the treatment themselves.

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