FINAL ESSAY: DEINSTITUTIONALIZATION OF THE MENTALLY ILL IN AMERICA

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ABSTRACT

The decades-long deinstitutionalization of psychiatric patients (from care in institutions to community-based supports) in the United States has been controversial. For certain individuals it has been a lifesaver, but for many more it has had negative consequences. By examining academic articles and media through interdisciplinary research, the ongoing effects of deinstitutionalization on psychiatric patients is explored. It is clear that the ideas associated with deinstitutionalization must innovate to better serve the mentally ill.
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Final Essay: Deinstitutionalization of the Mentally Ill in America

A common definition of deinstitutionalization is: “in sociology, a movement that advocates the transfer of mentally disabled people from public or private institutions, such as psychiatric hospitals, back to their families or into community-based homes.” (“Deinstitutionalization,” 2016). While concentrated primarily on the mentally ill, deinstitutionalization may also describe similar transfers involving prisoners, the developmentally disabled, or other individuals previously confined to institutions (“Deinstitutionalization,” 2016). The term has been described as a social movement, a government policy, and an era.

An alternative definition describes deinstitutionalization occurring when a complex set of customs, structures, and activities is modified or loses its reason for being (“Deinstitutionalization,” 2016). In recent years, the term has been used to describe the changing societal beliefs concerning marriage (a decades long weakening of the social norms that define partners' behavior (Cherlin, 2004)) and the debate concerning the drastic growth of the American prison system population (specifically, advocacy for a decrease in prison population and a corresponding increase in community mental health and substance abuse services) (Frazier, 2015).

Introduction: The Scale of Deinstitutionalization in America

According to Dumont (2009), the American psychiatric reforms of the 1960s promised a more humane and effective treatment for the severely mentally ill through a massive shift from state institutions to community-based services (p. 61). From a high of over 500,000 (about 2 percent of the American population at the time) in the 1950s, the U.S. state mental hospital population decreased to about 38,000 by the end of the 1990s.
Dickerson and Sharfstein (2015) have found that deinstitutionalization is an ongoing process in the United States; between 2005 and 2010 the number of state psychiatric beds decreased by 14% nationwide. This number continues to drop (p. 1).

The history of deinstitutionalization does not only concern the mentally ill. Developmentally disabled individuals have also been deinstitutionalized in the United States. Bagnall and Eyall (2016) have compared the deinstitutionalization of both groups, observing that deinstitutionalization began later for developmentally disabled individuals than for psychiatric patients, and that the process was more gradual and protracted (p. 28). They also argue that the deinstitutionalization of developmentally disabled individuals was far more thorough and successful for a number of reasons (examples include more family support for these individuals and better community support infrastructure (p. 28)). For this work, the focus will be on the psychiatric patients who have been affected by deinstitutionalization in the United States (this includes the patients who were initially moved from the institutions into communities, and the generations of patients who followed).

Deinstitutionalization in the United States has been controversial. Some have called it a policy failure and an unsuccessful social experiment. Critics have blamed deinstitutionalization for growing homelessness and increased involvement of the mentally ill in the American criminal justice system. Furthermore, researchers Yoon and Bruckner (2009) have found a potentially higher suicide rate amongst the most severe cases of deinstitutionalized individuals (p. 405). Yet there are also positive reviews of the process. Despite the seemingly unlimited amount of negativity related to deinstitutionalization, Washington Post journalist Harold Pollack states (2013):
“hundreds of thousands of people with severe mental illnesses now live safer, more dignified, and happier lives within their communities.” (p. 1).

So, what is the reality? How can interdisciplinary research assist in examining this complicated, controversial process? The issue requires interdisciplinary insight - deinstitutionalization and its effects are felt in almost every facet of American society. By integrating the disciplines - specifically history, psychology, sociology (the sub discipline medical sociology), law, and geography – I will attempt to answer this particular research question: has deinstitutionalization improved the lives of the severely mentally ill in America? I will show that deinstitutionalization – while a well-intentioned idea - has mainly failed the mentally ill. The community supports established by deinstitutionalization must be vastly improved to meet the needs of these individuals.

**Deinstitutionalization: Historical and Sociological Lenses**

Stroman (2003) observes that deinstitutionalization as a policy for state hospitals began in the period of the civil rights movement, when many groups were being incorporated into mainstream American society (p. 124). Numerous social forces led to the push for deinstitutionalization. Researchers, including Stroman (2003), list six main factors: criticisms of the conditions of public mental hospitals, incorporation of new drugs in treatment, support from President John F. Kennedy for federal policy changes regarding care for the mentally ill, shifts to community-based care, changes in public perception, and individual states' desires to reduce costs from mental hospitals (p. 124).

According to Roberts (1985), from the Middle Ages through the seventeenth century, mental illness was viewed as an abnormality brought on by evil spirits. It was common for the mentally ill to be executed or persecuted as witches (p. 78). Those
suffering from mental illness were sometimes kept at home in chains while others were
thrown out of their community and forced to survive on their own in the streets (p. 77).

Roberts (1987) asserts that the first major effort to provide humane care to the
mentally ill occurred in the late eighteenth and early nineteenth centuries. This major
reform movement has become recognized and referred to as moral treatment (p. 78).
Three humanitarian reformers initiated moral treatment, which had shown some
effectiveness in treating mental illness: Dr. Philippe Pinel in France; William Tuke in
England; and Benjamin Rush in the United States (p. 78). In the early 1800s, Dr. Rush
introduced moral treatment at Pennsylvania Hospital in Philadelphia, the first hospital in
the United States dedicated to providing humane moral treatment for the mentally ill (p. 79).

In 1841, Dorothy Dix visited the East Cambridge Jail in Cambridge, Massachusetts, and what she saw deeply troubled her. She observed mentally ill
individuals who were inappropriately incarcerated and inhumanely treated (Fisher et al, 2016). This observation set her on a multi-state course of reform that would conclude in
the creation of numerous institutions for housing persons with mental illness. The
majority of these were built across the eastern half of the United States starting in 1850
(p. 5). These institutions, it was believed, would provide more humane treatment to the
mentally ill than had been provided in jailhouses (p. 5). Money would also be saved by
treating patients and returning them to productive lives, rather than housing them
indefinitely at public expense (p. 5).
Problems Start

Soon, these state mental hospitals began to function as what economists call a “free good” (p. 6). Liberal regulations surrounding involuntary admission and retention allowed police, family members, and others to use the state hospital as a dumping ground for persons who were mentally ill, developmentally disabled, suffering from addiction, or inclined to perform acts that were considered socially unacceptable (p. 6). Descriptions of state institutions operating in the latter part of the 19th and early 20th centuries in the United States describe a mass of patients confined in state hospitals because there were few alternative settings and the institutions were easily accessed (pg. 6).

These facilities proliferated rapidly during the 75 years that state governments invested in them (p. 6). The lax legal statutes that allowed individuals to be easily admitted and retained, coupled with the attractiveness of these settings as places to send not only those with mental illness, but also the generally undesirable, lead to uncontrolled growth in the institutions’ populations (p. 6). As populations increased, the institutions received less and less public attention. This was due in part to the stigma of having a family member in an institution, and also because these facilities were located outside of large population centres (pg. 7).

Soon, these institutions became overcrowded. The invisibility of patients residing in these facilities led to little public interest in or attention to what transpired in them, and continued underfunding led to perennial short staffing (p. 7). It appears that as long as individuals detained in public psychiatric hospitals were not in the community, few were concerned about what happened to them (p. 7). The lack of effective treatments for the
illnesses from which many patients suffered led to the growth of ‘chronic patients’ whose conditions failed to improve (p. 6).

An expanding population of persons with largely untreatable psychiatric illnesses and static human and capital resources led to abuses that would come to light during the mid-20th century (p. 7). Accounts of maltreatment in psychiatric facilities written by individuals who worked in state hospitals during World War II, journalists and others, revealed overcrowding, understaffing, serious abuse of patients, dietary budgets of pennies per day per patient, nakedness and filth (p. 8). By 1950, public opinion of state mental hospitals was increasingly negative (p. 8).

**The Antipsychotic Era**

One of the most enduring, and central tenets of modern psychiatry is that deinstitutionalization was caused by the efficacy of antipsychotic drugs, particularly chlorpromazine and reserpine, that were introduced in the 1950s (Pow et al, 2015). The idea that deinstitutionalization was a direct result of psychotherapeutic drugs is frequently expounded by the pharmaceutical industry (p. 9). It has been suggested that such assertions are intended to enhance public and professional perception of drug efficacy. Pow et al. (2015) assert that the attribution of drugs as the causative agent of deinstitutionalization is, at best, simplistic, and at worst, misleading. After the introduction of antipsychotics, both discharge and readmission rates increased, and no significant differences between them occurred until after 1961 (p. 9). Beginning at that time, the decline in mental hospital populations coincided with changes in public policy, not with the introduction of new antipsychotic medications (p. 10).
Harcourt (2011) describes President John F. Kennedy’s message to Congress in 1963, which outlined a federal program designed to reduce by half the number of persons in mental institutions, and proposed replacing state mental hospitals with community mental health centres (p. 2). These proposals were ultimately enacted by Congress in under the Community Mental Health Centres Act. President Kennedy’s aspiration of a fifty percent drop, underestimated the extent of deinstitutionalization that would take place (p. 3). The passage of the Community Mental Health Centres Act in 1963 would be followed by the largest institutional migration that has ever occurred in the United States. From 1965 to 1975, the inpatient population in state mental hospitals would plummet a stunning 59.3 percent (pg. 2).

According to Yohanna (2013), beyond the passing of Community Mental Health Centres Act of 1963, the most important change in federal law was the introduction of Medicaid, which shifted funding for people with mental illness in state hospitals from the states’ responsibility to a shared partnership with the federal government (p. 3). This created an incentive for states to close the facilities they funded on their own and move patients into community hospitals and nursing homes partially paid for by Medicaid and the federal government (pg. 4).

During the 1960s, Testa and West (2010) have observed that American enthusiasm for a civil rights approach to all social problems produced a body of case law, which made it virtually impossible to give medical help to anyone without their consent, no matter how desperately their families and others know it is needed to protect them and others (p. 31). Additionally, the civil rights movement - alongside the antipsychiatry
movement - lent to the public push for the abandonment of mental institutions in favour of more humane psychiatric care (p. 32).

According to Lamb (2001), it must be stressed that the rationale for pursuing deinstitutionalization, reflected justifiable concern for the well-being of mentally ill persons, many of whom were living miserable lives inside the state hospitals (p. 1040). This rationale encompasses several important assumptions. First, it was widely assumed that community-based care would be intrinsically more humane than hospital-based care. Second, it was similarly assumed that community-based care would be more therapeutic than hospital-based care. Third, it was further assumed that community-based care would be more cost-effective than hospital-based care (p. 1040).

The Washington Post published an article that described the lives of recently deinstitutionalized patients in Maryland (Boodman, 1985). For one patient in particular – Michael Wayne Allen – life was especially difficult:

“In the three years since he left a Maryland state mental hospital, Michael Wayne Allen has learned a lot about the outside world. Allen, 32, has scouted abandoned houses where he can sleep if the shelters in Montgomery County are full. He knows which trashcans near the Smithsonian Institution contain the best scraps of food discarded by tourists. He has discovered that if he walks very fast, he can sometimes escape the evil demons that he thinks inhabits his body and make him stand on street corners shrieking at strangers.” (p. 3)

Allen had been discharged from Springfield Hospital Center in Sykesville, Maryland, in 1978, as part of the state’s deinstitutionalization efforts. He was diagnosed as having chronic schizophrenia, a serious thought and mood disorder characterized by
hallucinations. After discharge, he was expected to re-establish his life in Montgomery County – an hour’s drive away from the hospital grounds (p. 3). He was also expected to find a place to live, apply for benefits, and get a job. Boodman (1985) went on to describe other patients in the same sad predicament as Allen: “Frightened, with little money and often heavily medicated, released patients are expected to seek social services from agencies that had little contact with the hospital that had treated them. Not surprisingly, many end up on the streets, in jail or back in the hospital.” (pg. 3)

Deinstitutionalization: A Failure?

“With the advantage of hindsight, we can see that the era of deinstitutionalization was ushered in with much naiveté and many simplistic notions of about what would become of the chronically and severely mentally ill. The importance of psychoactive medication and a stable source of financial support was perceived, but the importance of developing such fundamental resources as supportive living arrangements was often not clearly seen, or at least not implemented. Community treatment was much discussed, but there was no clear idea of what it should consist of.” (Lamb, 1984)

According to Nelson (2010), deinstitutionalization in the United States was not accompanied by the sufficient development of community supports (p. 124). Even though many of the problems faced by individuals admitted to psychiatric hospitals are social, economic, or interpersonal in nature, the support that they received upon discharge in the early days of deinstitutionalization, and still today in many cases, usually consisted solely of medication (p. 124). This lack of support has led to numerous challenges to treatment outcomes for the severely mentally ill, which will be discussed below.

A Sociology Lens: Homelessness in America

Lamb (2006) observes that housing emerged as a significant problem in the era of American deinstitutionalization, with many former patients living in psychiatric ghettos, consisting of for-profit board-and-care homes, semi-institutional facilities (half-way
houses), foster families or poor quality rental housing (p. 899). Lamb (2006) goes on to argue that homelessness among the chronically mentally ill is closely (and definitely) linked with deinstitutionalization (p. 899). The lack of planning for structured living arrangements and for adequate treatment and rehabilitative services in the community has led to many unforeseen consequences such as homelessness, and the shunting of many of the mentally ill into the criminal justice system (p. 899).

The homeless population in the United States is difficult to count, and estimates for the country vary widely. According to Lamb (1984), “homelessness is closely linked with deinstitutionalization in the sense that three decades ago most of the chronically mentally ill had a home - in the state hospital. Without deinstitutionalization it is unlikely there would be large numbers of homeless mentally ill.” (p. 899)

Mental Illness and Criminality

According to Raphael and Stoll (2013), since the 1970s, much concern has been expressed about the number of mentally ill persons found in American jails and prisons (p. 219). The prevalence of mental health problems is extremely high among American prison and jail inmates. Approximately half of state and federal prison inmates and over sixty percent of jail inmates report having mental health problems or symptoms indicative of mental illness (pg. 219). Raphael and Stoll (2013) argue that it is certainly the case that a relatively high proportion of the currently incarcerated mentally ill would not have been incarcerated in years past and would likely be receiving inpatient treatment in a mental health facility (p. 219).

In California, research conducted by Lurigio and Harris (2002) has shown that the shift from state to local mental health services was unexpectedly accompanied by a sharp
increase in the population of the mentally ill within California’s criminal justice system (p. 2). Studies conducted in the 1970s and 1980s have concluded that emptying the state’s public mental health hospitals had forced a large number of deinstitutionalized patients into the criminal justice system. Recent studies have reaffirmed that the problem is increasing (p. 2)

**Policing**

Lurigio and Harris (2002) have also found that a contributing factor to the processing of the mentally ill through the American criminal justice system is the adoption of law enforcement strategies that emphasize quality-of-life issues, and zero tolerance policies in response to public-order offenses, including loitering, aggressive panhandling, trespassing, disturbing the peace, and urinating in public, which have brought into the criminal justice system large numbers of individuals for publicly displaying the signs and symptoms of untreated, serious mental illness (p. 11). The implementation of public-order policing tactics has outpaced the development of diversionary programs for the mentally ill (p. 11).

Beginning in the late 1980s and throughout the 1990s, police departments across the United States (especially in urban areas) launched these “zero tolerance” initiatives to suppress public-order offenses (p. 12). Intended to improve the quality of life in cities, these strategies have resulted in a substantial surge in the arrests of individuals who are homeless, suffering from mental illness, and addicted to substances (p. 12). In many cases, the offenses that result in arrest are indicative of mental illness. Arrests for these relatively minor offenses also can lead to more serious charges, such as resisting arrest or assaulting a police officer. According to Massaro (2005), the unintended consequences of
“zero tolerance” public-order enforcement strategies on the mentally ill was noted in the early 1990s by several researchers whose findings contributed to the development of diversion programs, specialty courts, and specialized law enforcement training initiatives designed to keep the mentally ill from criminal justice processing (p. 1).

Lamb and Weinberger (2005) argue that the arrest of a mentally ill person can have long-term consequences (p. 529). Specifically, the arrest will be noted on a computerized criminal record that can influence future law enforcement and court decisions. A permanent “criminal” label can make police officers and judges more willing to subject these persons to future criminal justice processing. This concern applies especially to persons who commit fewer, rather than more, serious crimes (p. 529).

**A Psychology Lens: Modified Labelling Theory**

According to Wright (2000), modified labelling theorists have long argued that the stigma of mental illness has important consequences for the lives of people with mental illness (p. 68). Social rejection is an enduring force in the lives of people with mental illness and these experiences are central to the understanding of poor self-concepts described by many former psychiatric patients (p. 84). In 2000, researchers explored changes in a cohort of recently deinstitutionalized mental patients' self-esteem and experiences with social rejection using data from a three wave panel survey conducted while institutionalized and over a two-year period following the patients’ discharge from a long-term state hospital. Results indicate that social rejection is a persistent source of social stress for the discharged patients (p. 84). Moreover, these experiences increase feelings of self-deprecation that, in turn, weaken their sense of mastery. Where the patients received their follow-up care – whether in a community
setting or in another state hospital – had little impact on their self-related feelings or on their feelings of social rejection. (p. 85)

**Treatment outcomes**

Lamb’s research (2001) has shown that deinstitutionalization has benefitted some patients, but failed many more. Deinstitutionalized mental health care is potentially more humane and more therapeutic than hospital care, but this potential is realized only when certain preconditions have been met (pg. 1043). These preconditions include establishing holistic policies: tailoring service plans to individual and cultural needs and facilitating access to longer-term hospital care in severe cases (p. 1043). The central problem that now needs to be addressed is society’s obligation to provide adequate care and treatment to these individuals in the community (p. 1044). Lamb (2001) also states that with the advent of the modern antipsychotic medications and psychosocial treatments, the great majority are able to live in a range of open settings in the community — with family, in their own apartments, in board-and-care homes, and in halfway houses (p. 1044).

Nevertheless, there remains a minority of individuals who have chronic and severe mental illnesses that need highly structured 24-hour care, often in locked facilities, and these individuals must not be overlooked (p. 1044). The fact that a significant proportion of this minority are not receiving sufficient care but are instead living in jails, on the streets, or in other unacceptable situations is evidence that adequate community care has not been provided for some of the most severely ill persons (pg. 1044).

I agree with Lamb in that “deinstitutionalization has left us with a heightened awareness of the humanity and needs of mentally ill persons” (pg 1042). Whether we like it or not, the lives of most chronically and severely mentally ill persons have now
changed permanently from institutionalized living to community living (p. 1044).

According to Lamb (2001), “what is needed now is the will and the funding to realize the potential of deinstitutionalization to improve the lives of all severely mentally ill persons, whether they reside in the community or in hospitals (pg. 1044). What is needed in the American mental health system is a vast expansion of community housing (and other services), plus increased funding to meet the needs of the chronically mentally ill (p. 899).
References


