Deinstitutionalization: A Public Policy Perspective

Events initiated in the late 1940s and early 1950s have dictated the care of the mentally ill as it exists today. The major trend, primarily legal and sociopolitical in nature, has been deinstitutionalization. Its implementation as a policy is cited as one cause of homelessness among the mentally ill. Available services for the homeless mentally ill are fragmented and fraught with multiple barriers. This article will explore these issues and discuss implications for the mental health professional.

Various historical events have led to the depopulation of state mental institutions. The National Mental Health Act of 1946 initiated public awareness of mental illness. Media coverage concentrated on exposés of abusive conditions in mental hospitals. Meanwhile, basic, clinical, field, applied, and administrative research flourished in the mental health arena. Innovative therapies were being instituted, such as the intensive treatment of the acutely ill, psychosurgery, and psychotherapy. Tranquilizers were introduced in the early 1950s, with other psychoactive medications soon following.

Congress enacted the Mental Health Study Act in 1955, prompting the creation of the Joint Commission on Mental Illness and Mental Health. Mental health needs in general were researched and encouraged in President Kennedy’s report to Congress on mental illness and mental retardation in February 1963. The policy of deinstitutionalization was formulated into the primary legislation of the Community Mental Health Centers Act of 1963. The locus of care began to shift from the state mental institution to the community (National Institute of Mental Health, 1977).

The concept of deinstitutionalization was not inherently bad (Talbott & Lamb, 1984). Deinstitutionalization was established during an era of social reform in response to poor hospital conditions and the documentation of the social breakdown syndrome associated with institutional living. The syndrome was evidenced by lack of initiative, submission to authority, withdrawal, and excessive dependence on the institution (Lamb, 1984). The political focus was on equity and access to care (Mollica, 1983). Legal issues at the time were involuntary commitment, right to treatment, right to refuse treatment, right to protection from harm, right to decent living conditions, and right to the least restrictive environment needed for care (NIMH, 1976).

Operationally, B. Brown, Director of National Institute of Mental Health, describes deinstitutionalization as having three essential components: Prevention of inappropriate mental hospital admissions through the provisions of community alternatives for treatment.

- The release to the community of all institutional patients who have been given adequate preparation for such a change.
- The establishment and maintenance of community support systems for noninstitutionalized persons receiving mental health services in the community (NIMH, 1976). As amended in 1975, the basic services required by law of the community mental health centers were inpatient and outpatient care, day care, and other partial hospitalization, emergency, specialized services for the young and elderly, consultation and education services, screening for referral to a state mental health facility for inpatient treat-
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ment, aftercare, transitional care (e.g., halfway houses), and substance abuse programs as needed (NIMH, 1977).

However, in the more than 20 years since its inception, the implementation of deinstitutionalization has received major criticism. From a functionalist perspective, problems have arisen from the failure to provide alternative solutions to basic functions that had been carried out by the mental hospital (NIMH, 1976). These institutions provided “asylum,” a safe haven from exploitation by the external world, especially during crises. They also provided medical care, patient monitoring, respite for family, a social network, food, shelter, and needed support and structure (Lamb, 1984).

Furthermore, there was a failure to designate responsibility for these persons with chronic mental illness. For example, on a purely fiscal level, states encouraged discharge of patients to the community because the majority went to nursing homes, board and care homes, or other residential alternatives supported with federal, local, or private funds (NIMH, 1981). Local governments complained that they did not have the financial resources to deal with this national problem, while federal governments insisted that problems originated locally and efforts to resolve them should start there (Levine, 1986).

Community mental health centers have struggled to survive amid an era of conservatism and budget cuts. To start, their implementation did not rest on strong scientific principles realized through careful research (Lamb, 1984). The chronically mentally ill and their
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needs were never clearly explored (Bachrach, 1984). Services were at a bare minimum with an absence of the outreach services so gravely needed. The most severely impaired chronic mental patients were often seen as less personally rewarding to serve, and thus their needs were frequently ignored (NIMH, 1976). Finally, the dreadful lack of housing undermined the continuity of the most serious efforts (Baxter, 1984).

Persons with chronic mental illness released into the community are poor advocates for themselves, and are often functionally inadequate in the social arena. They tend to reside initially in board and care homes that were hastily organized during the rapid depopulation of state hospitals. These residences provide few of the necessary functional services and rely on the individual to independently navigate the community mental health system. Because of chronic disorganized behavior and fragmentation of the service system, many of these people find themselves in the swelling ranks of the homeless (Lamb, 1984).

Homelessness is more than a lack of residence. It involves a lack of food, clothing, medical services, and social support. Sociologically, it is a disaffiliation and detachment from social structure (Bachrach, 1984). Causes of homelessness in general are many and include unemployment, gentrification of urban areas without replacement of low income housing, and chronic mental disorders (Talbott & Lamb, 1984). Persons with chronic mental illness, specifically, are often drifters trying to avoid problems and social intimacy and attempting to maintain independence. They often discontinue their medications, become psychotic, disorganized, and resort to living on the street (Lamb, 1984). These factors are complicated by aggressive admission diversion policies by state hospitals, symptomatology exacerbations from substance abuse, and a disappearance of the skid row counterculture that once protected them (Bachrach, 1984).

There also exists an increasing new segment of the homeless mentally ill: the young who have never been institutionalized. These people are products of the baby boom generation and currently are at the age most at risk for developing a mental illness, especially schizophrenia, a major contributor to chronicity (Bachrach, 1984). This population is less passive and somewhat more forceful in using various agencies but is still dreadfully lacking in integrative function (Lamb, 1984).

The mentally ill homeless have very different needs than the homeless overall. Specifically, they require comprehensive support systems with assured continuity of care. Comprehensive support must include 24-hour crisis stabilization services, a variety of residential and treatment settings, a complete offering of treatment services, and available transportation. Specifically, they need concrete services such as showers, delousing, clothes, food, meals, emergency money, and provision of a mailing address. Clinical assistance can be accomplished by social counseling, assistance in finding a job, housing, substance abuse rehabilitation program, and by teaching banking, time orientation, how to fill out forms, and how to prepare for a hearing. Frequently, they need to be accompanied to government offices to help decipher regulations (Baxter, 1984).

Full benefit of any program for the homeless population can only be realized by removing all barriers to access. Services must be planned for long duration secondary to the nature of chronic illness. Resources must be readily available and encouraged for client use, there must be a source for payment, and they must be in the area for treatment. Location is a particular problem applying to most services (Bachrach, 1986).

Currently, the mentally ill homeless encounter a multiplicity of problems. Financially, they are at a complete loss because the major source of income for persons with chronic mental illness—supplemental security income—requires residency (Lamb, 1984). They often are involved with substance abuse, which exacerbates symptoms, and are frequently arrested for bizarre behavior. They become fearful, untrusting, and withdrawn. Many programs differentiate between mental illness and substance abuse and deny those who have both problems (Bachrach, 1984).

From chronic living in poor and dangerous conditions without proper nourishment, many have characteristic medical problems of infestation, peripheral vascular disease, cellulitis, leg ulcers, and a variety of other chronic medical disorders. Major and petty trauma is frequent, secondary to robbery, assault, and rape (Brickner, 1984).

Services are often provided by several agencies with divergent philosophies, eligibility criteria, standards of care, and referral procedures. They are
sometimes geographically distant. The bureaucracy becomes too difficult to penetrate and the homeless withdraw and return to life on the street (Goldfinger, 1984).

Shelters for the homeless provide food and clothing in addition to the basic shelter function. Some provide minimal counseling or referral. Generally, shelters are necessary but purely symptomatic measures: while they sustain life they do not address the basic causes of homelessness. Often shelter users accept these services and return directly to dangerous street life (Lamb, 1984).

Because of the prevalence and reliance on shelters as a service to the mentally ill, some claim they have become mini-institutions (Lamb, 1984). Shelters have been in existence many years and have developed a vested interest in themselves. Operators identify with the homeless and resent impetus to change from the outside. In this way, these proprietors collaborate with politicians in maintaining the status quo (Bassuk, 1984). However, shelters lack the therapeutic environment of the institution. Thus, the implementation of deinstitutionalization has led to “transinstitutionalization” and “detreatmentization” (Talbott, 1985).

Legal issues are being questioned. For example, is the least restrictive environment always in the best interest of the person with mental illness? Some propose that the optimal setting needs a degree of structure and therapeutic intervention, sometimes just to maintain the person's safety within the community (Peele, 1984).

Case management is one concept that is emerging in an attempt to integrate care for the homeless mentally ill. The case manager arranges appointments and referrals, monitors actual service delivery, coordinates personnel from various agencies, and acts as a patient advocate (Bachrach, 1984). Outreach and follow-up must be aggressive. The case management concept provides for the individualized programming needed secondary to the fearfulness, resistance, and distrust of so many of the chronically mentally ill. Operational definitions of the job, such as qualifications and scope of responsibility, are lacking in the literature.

The American Psychiatric Association formed a task force to address the complex needs of the homeless mentally ill, delving into homelessness, deinstitutionalization, and related concepts. The major recommendation was:

To address the problems of the homeless mentally ill in America, a comprehensive and integrated system of care for this vulnerable population of the mentally ill, with designated responsibility, with accountability, and with adequate financial resources, must be established (Talbott & Lamb, 1984, p. 5).

This is not a goal that can be met with a simple, quick solution; all issues must be carefully evaluated. Of primary importance, however, is public policy. Mental health professionals can act in the greatly needed role of patient advocate and can provide information on the characteristics and needs of the homeless mentally ill, causes, and frequent barriers to care encountered by this population. Finally, the mental health professional must be actively involved in welfare and housing reform. A therapeutic, rehabilitative dimension must form the basis for changes in deinstitutionalization policies and overall mental health reform.

References
Lamb, H.R. Deinstitutionalization and the homeless mentally ill. In H.R. Lamb (Ed.), The
Deinstitutionalization


**Deinstitutionalization KEY POINTS**

**The Homeless Chronically Mentally Ill: Deinstitutionalization: A Public Policy Perspective. Riesdorff-Ostrow, W. *Journal of Psychosocial Nursing and Mental Health Services* 1989; 27(6):4-8.**

1. Deinstitutionalization was initiated in an era of social reform to protect the rights of the mentally ill; however, a strong research base was absent and led to major flaws in the policy’s implementation.

2. The chronically mentally ill are frequently poor advocates for themselves and, without even the most simple needs fulfilled, end up homeless.

3. The homeless mentally ill require comprehensive support systems with assured continuity of care. An emerging concept to deal with this issue is that of case management.

4. The mental health professional can strive to influence future public policy as patient advocate and nonpartisan educator.

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