Institutionalization and Deinstitutionalization

As recently as the mid-20th century, the U.S. public mental health system consisted largely of the state hospitals. These hospitals, originally constructed for the humane asylum and "moral treatment" of those deemed mentally ill, had evolved into overcrowded, understaffed, and inadequate responses to the general welfare burden of society. Since that time, there have been many attempts to change the world of psychiatric treatment, including the use of medication and deinstitutionalization. Unfortunately, most of the efforts to change the treatment of persons with mental illness have not been successful. Although policymakers have promised changes in the current mental health system, meaningful changes are not going to happen until it is realized that community-based care is necessary and there is no "quick fix." For deinstitutionalization to be successful, there must be adequately funded community alternatives—other than jail, prison, homelessness, or early death—for individuals diagnosed as mentally ill.

Historical Progression of Hospitalization of Persons With Mental Illness

Through the first half of the 20th century, state hospitals provided care, housing, employment (usually unpaid), and social control of people deemed unable to meet life's daily demands. Mental illness, alcoholism, mental retardation, advanced age, or chronic somatic illness, or a combination of these factors, were all reasons for admission. The census nationally peaked at 553,000 in 1955 and is today less than 10% of that number.

The evolution from small pastoral asylum to large, multiburdened institution—Pilgrim Psychiatric Center in New York had more than 14,000 patients in 1955—was less the result of a conscious, articulated social policy than a drift in policy by a relatively young nation struggling with immigration, urbanization, poverty, disability, and industrialization.

By the 1950s, several factors had combined to alter this approach to serious mental illness. First, institutional abuses became widely publicized, resulting in the creation of the Joint Commission on Mental Illness and Health in 1955. Six years later, this commission was to produce recommendations for a community mental health system in a book titled *Action for Mental Health* (1961).

Second, in 1952, the world of psychiatric treatment was to change profoundly with the development of the antipsychotic drug Thorazine (chlorpromazine) by Henri Laborit. The introduction of this drug meant that many people with serious mental illnesses could control their symptoms with medication.

Third, the Civil Rights Movement began to gather momentum. Initially focusing on persons of color, civil rights attorneys eventually turned their attention to other disenfranchised populations, including people with mental disabilities. Court decisions such as *O'Connor v. Donaldson* (1975) reinforced the liberty interests of psychiatric patients and limited the goal of involuntary hospitalization to prevention of harm, as opposed to the alleged best interests of the patient.

Eventually, these pressures resulted in the passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act in 1963. The bill was passed with optimism and fanfare and promised that high-quality mental health services in the community would be less expensive and more effective than hospital care. However, these promises were never kept.

Meanwhile, the cost of institutional care began to rise dramatically. In part, this too was due to the efforts of civil rights attorneys and federal courts. Eventually, large class actions such as *Wyatt v. Stickney* resulted in court-mandated improvements in institutional care, which dramatically increased staffing requirements and costs.

Deinstitutionalization

There was insufficient provision for the comprehensive needs of both discharged patients and future generations of people with serious mental illnesses. These needs—housing, social support, employment—were largely neglected in the early decades of deinstitutionalization. Treatment services were expanded but were often focused on those with less severe mental illnesses.

In many ways, the decades since the massive deinstitutionalization of the 1960s and 1970s have been devoted to repairing the flaws of that era. Community support systems and supportive housing were gradually increased—although demand vastly outstrips supply in every state. The growth of the family movement and consumer empowerment movement brought new advocacy to the needs of those attempting to manage and recover from severe mental illness.

The results of our nation's implementation of deinstitutionalization have been mixed. A recent study found that people with serious mental illness are dying 25 years earlier than the general population. Between one-fourth and one-third of America's 2.3 million

homeless persons have a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. Furthermore, 6% to 20% of the nation's more than 2 million incarcerated people are estimated to have a serious mental illness. The high prevalence of mental illness in local jails and state prisons eventually became known as the “criminalization” of mental illness.

Yet when deinstitutionalization is done thoughtfully, the results are impressive. In Vermont, Courtney Harding and her colleagues found that linking comprehensive rehabilitation programs, housing, and clinical support to hospital downsizing produced positive, measurable results: Over half the patients 30 years later were productive, living independently with little social impairment, and over two-thirds were functioning “pretty well.”

Implications for the Future

There are many lessons to be drawn from the flaws and triumphs of deinstitutionalization. The first is that public policy implemented without consultation with those directly affected—patients and their families in this case—can lead to major folly.

A second lesson is the danger of overpromising. Policymakers overestimated the impact of medication alone, ignoring the need for housing, social support, and an empowered, productive role for patients, all of which are essential to the recovery process.

Finally, society needs to learn that today there is no quick-fix or inexpensive solution to devastating, severe mental illness. Hospitals cost more than community services, but coordinated, comprehensive systems that include treatment, housing, empowerment, social support, and employment are also costly. Convincing taxpayers to support such a system remains a major challenge.

Like it or not, community-based care is here to stay. The costs of hospital care remain prohibitive, and although some states have relaxed civil commitment statutes, in general, long-term hospital treatment remains targeted only at those with the most disabling conditions. Increasingly, the necessity for long-term hospital care is being questioned for anyone who has not committed a serious crime.

However, as our public policy remains committed to community living for persons with serious mental illness, the gap between needs and resources must continue to shrink. Alternatives to jail, prison, homelessness, and premature death must be funded and implemented if deinstitutionalization is to keep its lofty promises, and there is much work yet to be done.

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Further Readings

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Entry Citation:

Dvoskin, Joel A. Bopp, James Dvoskin, Jennifer L. "Institutionalization and Deinstitutionalization." *Encyclopedia of Psychology and Law.* 2007. *SAGE Publications.* 17 Jul. 2011. <http://sage-ereference.com.ezproxy2.library.arizona.edu/view/psychologylaw/n151.xml>.