Deinstitutionalization of the mentally ill: Oversimplification of complex issues

Deinstitutionalization is the predominant public mental health policy in most states. An analysis of this policy in one state from a political-economic perspective gives support to the hypothesis that deinstitutionalization results in a two-class system of mental health care based upon the client's ability to pay. Inequalities exist in opportunities for care that are appropriate for the pathology suffered by the chronically mentally ill, and patients' basic needs are often unmet. Corporate actors involved in developing mental health policy overpower clients as well as nurses in the distributive process. The impact of this policy on quality of care and nursing is significant.

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DEINSTITUTIONALIZATION of the mentally ill has become the predominant public mental health policy in most states. This policy has been supported by a curious marriage of liberals who decry the custodial level of care in state mental hospitals and conservatives who see the closing of expensive institutions as an easy way to save tax dollars.[1] Deinstitutionalization has been effected by a two-phase process of discharging long-term patients from state hospitals and making it increasingly difficult to admit new patients. Nationally, the public mental hospital census has decreased 70% from 559,000 patients in 1955 to approximately 150,000 in 1980.[2] The Massachusetts public mental health facilities census has declined 86% from a peak of 23,000 in the 1950s to 3,167 in 1980.[3]

This article discusses deinstitutionalization as a political-economic solution to a complex set of problems. A brief historical overview of public mental health care in the United States provides a basis for

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understanding some of the contemporary issues associated with deinstitutionalization. The reports of the Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts were analyzed to demonstrate the inequalities in opportunity for appropriate mental health services that result from the two-class system of services now in place in one representative state. The impact of this policy on quality of care and nursing is discussed.

THEORETICAL FRAMEWORK

The theoretical framework for this article is drawn from Lenski[4] and from Coleman.[5] Social stratification is a specific field of study within sociology. Lenski posits that the major question in this area should be, "Who gets what and why?"[4(p1)]

Historically, conservatives and radicals have disagreed about the basic principles that govern the distribution of rewards in our society. Conservatives have believed that the existing system of distribution is basically just; radicals have believed that it is basically unjust.[4] Deinstitutionalization presents a unique situation where conservatives and radicals favor one policy for two completely different reasons.

Coleman discussed the emergence of "corporate actors" in modern Western society. Juristic persons, as corporate actors are called by the law, are intangible entities such as corporations, labor unions, and churches. Two stages of history of modern corporate actors can be conceptualized. In the first stage the corporate actor was never very far from the control of people. However, in the second stage of development, corporate actors have come to be largely autonomous and out of the control of people. Society has come to be strongly influenced by these powerful new actors.

Corporate actors such as federal and state governments, the medical profession, and labor unions have had significant impact on the deinstitutionalization phenomenon. Nursing has not exhibited a strong influence as a corporate actor in public mental health policy.

HISTORICAL PERSPECTIVE: PUBLIC MENTAL HEALTH CARE

A review of the historical perspective of public mental health care in the United States demonstrates a pattern of changing locations and shifting responsibilities that began in colonial America. Massachusetts was often the site of innovation and change in the mental health field.

The early public response

In colonial America, the relatively small magnitude of the prevalence of mental illness combined with a model of informal care in the family and the use of jails precluded a public response to the mental health needs of individuals.

Almshouses became established in the 17th and 18th centuries in urban centers. Population densities increased and a sense of societal responsibility and moral obligation toward indigent citizens took hold. The first American almshouse opened in Boston in 1661. Toward the end of the 18th century, the heterogeneity and overcrowding of the few almshouses in operation spurred the development of urban hospitals. These served to isolate physically and mentally ill persons from the criminals,

vagrants, indigent widows, orphans, and elderly persons who constituted the almshouse population. In 1729, Boston was among the first locations to call for the establishment of separate housing and care for the emotionally disabled. The momentum for this approach culminated in the incorporation and establishment of the Massachusetts General Hospital and the McLean Asylum by the General Court in 1811. McLean was largely supported through private philanthropy and sliding-fee scales. Although it was established in part to deal with the indigent mentally ill, the hospital eventually was perceived as having highly exclusive admission policies based on the client's ability to pay for care.[3]

Private, proprietary mental hospitals, modeled on the success of the nonprofit institutions, had their start in this period as well. Through the early 1830s, however, almshouses remained the locus of care for the majority of poor, emotionally disabled people.

The rise of public inpatient care

The first half of the 19th century saw the growth of private hospitals throughout the United States. However, it soon became apparent that these hospitals could not keep pace with the perceived need for care and shelter of mentally ill persons. Increasing urbanization and immigration had swelled the population of almshouses and taxed the ability of municipalities to provide shelter to all in need. Concurrently, two important forces merged to create a movement for a concerted public response to mental illness:

1. a belief in institutional shelter for a wide variety of dependent or deviant persons, and
2. the first theory and regimen of proactive care for mental illness, termed moral treatment.

The Calvinistic belief that social deviance is a natural outgrowth of innate depravity, deserving of punishment and discipline, gave way to lodging the cause of deviance within the structure and atmosphere of a rapidly changing society. Criminality and dependency were understood to be learned behaviors. Mental illness was gradually viewed to be the result of personal conflicts over the tension, disorder, and mobility of Jacksonian society. For the mentally ill, this indicated the need for provision of an orderly and routinized environment that would reimpose balance and stability in their lives. Merged with the humane and nurturance principles of the new moral treatment approach, the concept of the insane asylum was born.

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The Worcester State Hospital, opened in 1833, became a prototype that other states followed in providing care for indigent mental patients. State hospital development could not keep pace with increasing need or demand for inpatient care of city almshouse residents. The municipal mental hospitals emerged, with the Boston Lunatic Asylum being the first in 1839. Funding for public mental health care in institutions came from two sources. Local

communities paid a per capita fee for their own indigent patients and the state provided the buildings and the superintendent's salary. After 1904 the state took over financial responsibility for these patients.

The state mental hospital development was rapid in the middle to late 19th century. This was due in part to the efforts of Dorothea Dix, who undertook a personal crusade for expanded public provision of moral treatment in mental hospitals. However, inflated belief in the curative powers of inpatient care, supported by high discharge rates during the height of moral treatment, was quickly deflated. The public hospitals experienced a buildup of chronic patients, and bed capacity was unable to keep up with the demand for hospitalization. Resistance to higher state appropriations for the shelter and support of increasing numbers of immigrant patients developed. One major study undertaken during this period reinforced an identification of mental illness as part and parcel of the welfare and dependency problem. Support mounted in the state legislatures for the establishment of separate and exclusively custodial institutions for immigrants and "incurables."

Public institutions were seriously thwarted in their ability to offer therapeutic care by the 1860s. Overcrowding, low funding, and an inability to transcend cultural differences between mental health professionals and foreign-born patients obliterated the potential for care. Criticism of public care mounted. This was coupled with the sentiment that the rest of society deserved state-guaranteed protection from the acts and disruptions of mentally ill persons. The first state welfare department for the management of publicly funded programs for the indigent, including mental health care, was developed in Massachusetts in 1863. Later, a State Board of Insanity was created.[6] This was the first time that a policy-making body concerned primarily with the insane was created.

By 1875 the focus of psychiatric care for mental illness shifted away from the humanistic perspective of moral treatment to brain pathology. Institutional care began to deteriorate and proliferate at the same time. Biological determinism, cost containment, and economic recession led to a period of gloom for the mentally ill. By the turn of the century, hopelessness and warehousing replaced compassion, high cure rates, and hope.[3]

Twentieth century public mental health care

Public sentiment about mental health services incited a new wave of change after World War II. The depression and war effort had taken a severe toll on the mental hospitals by undercutting their funding and staffing. Exposés of the "snake pits" of the 1940s and the high incidence of military service rejections of draftees because of mental illness underscored the lack of resources to care for persons with emotional disabilities. The widespread acceptance of the psychoanalytic method and the concept of the therapeutic community marked a return to a humanistic, interpersonal approach to patient care.[3] The advent of psychotropic drugs in the 1950s facilitated the discharge of large numbers of patients from mental institutions.

The community mental health movement of the early 1960s was able to capitalize on the use of psychotropic medications

to deinstitutionalize even larger numbers of patients. The movement found support from fiscally conservative budget administrators and civil libertarians. In addition, the success of alternatives to traditional psychoanalysis, such as behavior modification, rehabilitation, social and community psychiatry, and concentration on the emotionally disturbed individual's social role fulfillment, led to a more optimistic outlook for patients with disabling mental illness. Community-based treatment in the patient's natural environment became the model of choice.

Fiscally conservative budget advisers lent their support to deinstitutionalization because they believed, despite cautions from leaders in the mental health field, that the care of patients in community settings would be less expensive than traditional inpatient care. Civil libertarians advanced deinstitutionalization through the judicial and legislative arenas. They advocated that patients' rights as guaranteed by the Constitution, statutes, and precedents meant the right to at least be free of institutions that provided no care and perhaps the affirmative right to care and treatment in community settings. These developments led to the adoption of the social commitment and legal prerogative of the mentally ill to live and, if they wished, to receive treatment in the least restrictive environment.

The changes in the mental health delivery system during recent years have been tremendous. Many of these changes appear to have been accompanied by, and sometimes precipitated by, financial issues. People with health insurance, public or private, are not dependent upon the state hospital or public mental health system.

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They may choose private psychiatric hospitals, psychiatric services in general hospitals, or less intensive services such as outpatient or day treatment services. Those who require long-term institutionalization and who have the financial resources for private care are not faced with deinstitutionalization. The political motive underlying the notion that mental hospitals are necessarily harmful is revealed by the lack of opposition to private hospitals that are not dependent upon public funding. Many private mental hospitals have locked and long-term units. Neither politicians nor the public view them as harmful or custodial because, unlike state hospitals, they have adequate resources to provide active treatment.[1]

Despite recent increases in entitlement to care in the private sector, the significant number of persons presently making use of the public hospitals continue to do so because of the limitations that remain in private care entitlement. Thus, a two-class system of care is perpetuated: a private system for those who have access through insurance and a public system for those who do not.

Federal legislation

Historically, there has been a peculiar intertwining of mental health care and government. Borus[1] postulates that this has resulted in a major change in the delivery of care that is the result of sociopolitical

and clinical considerations. A review of federal legislation provides a history of this relationship (see boxed material). Legislation has played a critical role in supporting and shaping mental health services through directly funded programs and regulatory activities.

INEQUALITIES IN OPPORTUNITIES FOR MENTAL HEALTH: THE BLUE RIBBON COMMISSION

In December 1979, Commissioner Robert Okin established the Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts. Dr. Okin had reached the conclusion that "the clinical needs of the remaining core population within the Commonwealth's state hospitals for the mentally ill would be met if they are treated not within the state hospitals, but within the general health care system just like people who have severe physical illness."[3] The Commission was asked to determine whether this conclusion was sound and, if so, how as a practical matter this fundamental transformation of a public mental health system could be achieved.

Corporate actors

The commission functioned for approximately one and one half years. During that time, six regional public hearings were conducted throughout the state. Approximately 50 different meetings were held with groups of mental health professionals, advocates, and former patients. A report of the commission was submitted that con-

Federal mental health legislation

1948	Establishment of the National Institute for Mental Health.
1955	Passage of the Mental Health Study Act: authorized the first national analysis and evaluation of the human and economic problems of mental illness. The final report, *Action for Mental Health,* provided the impetus for radical change in the structure and delivery of mental health care that has taken place over the last 20 years.
1963	Passage of the Community Mental Health Centers Act: encouraged the development of alternatives to state hospital inpatient care and allocated "seed monies" for the construction and staffing of community-based facilities that offered a range of residential and nonresidential mental health services.
1965	Passage of Social Security Act Amendments: provisions in the Social Security legislation provide the major support for federal subsidization of mental health costs largely through Medicare and Medicaid reimbursement programs.
1974–1975	Passage of Health Planning Legislation (PL 93-641 and PL 94-63): includes provisions for the integration of mental health treatment services and general health services network and requires state mental health authorities to plan for the elimination of inappropriate mental hospital admissions, for the availability of community-based services, and for the upgrading or enforcement of standards of care.
1980	Passage of The Mental Health Systems Act (PL 96-398): provides for the expansion of services to currently unserved or underserved groups, especially chronically mentally ill, minority, young, and elderly persons.

tained a majority opinion and a dissenting, minority opinion. Data for this paper were obtained from both the majority and minority reports and from the transcript from the Salem public hearing.

The Blue Ribbon Commission may be viewed as a corporate actor that was a source of power in and of itself. Four factions of the groups interested in the status of the public sector mental health services were represented on the commission: medicine, nursing, and other providers; former state hospital patients; organized labor that represents the vast number of nonmanagerial employees in state institutions; and public officials such as judges, legislators, and the heads of regulatory agencies. An analysis of the committee membership demonstrated that men (30 of 37) and physicians (10 of 37) controlled the majority of positions on the commission. Two subcommittees, the executive committee and the finance committee, were also analyzed. The executive committee ($n = 9$) was composed of eight males, one physician, and no nurses. The finance committee ($n = 6$) was composed of all males, two physicians, one priest, one labor representative, two insurance representatives, and no nurses. This review of the decision-making bodies of the commission supports Navarro's thesis that there is very little representation of women and of the working classes in decision-making bodies of the health care sector in the United States.[7]

Major themes

The major themes distilled from the testimony of the Salem hearing supported Lenski's conceptualization of the distributive process and Coleman's notion of corporate actors.

A two-class system of care, dependent upon the patient's ability to pay, exists. A physician director of a community mental health center testified, "In effect, the criteria for sending a person to the state hospital is not whether or not they are mentally ill so much as whether they can pay for the hospitalization. I think the staffing patterns are different. I think the programs are different. I think the level of expertise in the private sector is greater than in the state hospitals."

Corporate actors have entered a second stage of development in the 20th century. They have become largely autonomous, out from under the control of people. A mother of a current mental patient told the committee, "Current changes that removed our friends and loved ones from hospitalization and threw them into the community without even the basic necessities that we accept as normal is at the very least cruel and inhumane. If the laws of the Commonwealth apply to the Commonwealth, the implementers of this practice would themselves be in court today."

When people are confronted with important decisions where they are obliged to choose between their own or their group's interest and the interest of others, they nearly always choose the former. A local mental health association member said, "As I see it, the basic premise of the Department working toward deinstitutionalization is not based on the philosophy of quality patient care, but is based on trying to save money for the Commonwealth, trying to save money for the taxpayers."

Organizational offices and other institutionalized roles with their established rights and prerogatives are widely sought because of their instrumental value to the individual. A psychiatrist testified that "one of the key reasons, we feel, that the Mental Health Unit at Salem Hospital has been successful is the continued principle that all admissions are handled by the physicians; no one is admitted without the clearance of a private physician."

The demand for the rights of women in the health sector is intrinsically related to the demand for a more democratic, representative, and accountable system that we have today. This need was articulated by a psychiatric nurse who said, "It is extremely difficult to understand why there is *one* professional psychiatric nurse on this commission and ten MD's."

The vignettes provided are obviously not inclusive of all the concerns and thoughts presented to the commission. They do, however, demonstrate the nature of the political process that oversimplifies complex issues, such as economic, philosophical, and clinical concerns of mental health treatment, so that a single solution can be advocated that will overcome the inertia inhibiting major change in governmental policy or practice.[1]

Major recommendations of the commission

The majority report of the commission concurred with Dr Okin's hypothesis that deinstitutionalization should proceed. The suggested time frame for closure of all regional hospitals was five years. Eight recommendations were provided by the majority report to support and facilitate the closing process, including:

- appointment of a transition panel to oversee the closure process;
- development of three different managements over the next three years;
- allowance for changes in the contracting system;
- development of programs based on client needs;
- emphasis on setting and monitoring standards of care;
- consolidation of planning, standard setting, and monitoring in one state agency;
- development of a statewide client advocacy system for fiscal year 1982; and
- formation of a coalition of interested representatives to lobby for implementation of the commission's recommendations.

The substantive difference in the minority report centered around the "explicit social obligation of the Commonwealth to provide mental health care to all who need it, including residential care."[3(p237)] This view flies in direct opposition to the attempt to privatize care of the mentally ill. The minority view provides an option to address the issue of caring for the chronically mentally ill based on clinical treatment decisions rather than on arbitrary political or economic factors. It does not, however, offer an opportunity to substantially revamp the two-class system that is in place.

It may be postulated that the limited ability of the minority reporters to propose sweeping changes is due in part to their understanding of the public's reluctance to

pay higher costs for quality care for the mentally ill.

IMPACT ON QUALITY OF CARE

Deinstitutionalization has had a major impact on the quality of mental health care for the chronically mentally ill. Patients were discharged to a community but not necessarily integrated into a community-based system of care. Many patients became homeless and unable to obtain the basic necessities of life such as food and shelter. Other patients went directly from state hospitals to nursing homes.[8]

In most states, criteria for commitment require that the person be found, as a result of mental disorder, dangerous to him or herself or others.[9] Some authors have argued that these laws have resulted in transinstitutionalization or criminalization of mental illness.[10] More psychiatric patients are being sentenced to jail. Increasing numbers of county jail administrators claim that their facilities have become depositories for persons who would formerly have been committed to state mental hospitals. United States prisons and jails currently manifest a suicide rate three times greater than that outside penal institutions.[11]

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Finally, readmission rates to state hospitals or community mental health centers have increased. One study reported that 50% of the people released from large mental hospitals are being readmitted within a year of discharge.[12]

IMPACT ON NURSING

Deinstitutionalization has impacted nurses in all areas of practice. Psychiatric nurses who remain in state hospitals are faced with the challenge of caring for the acutely ill patient with fewer resources than colleagues who work in the private sector. Fewer resources are evidenced by higher nurse-patient ratios and a mix of staff that is heavily weighted by nonprofessional aides.

Nurses who practice in emergency services, medical-surgical areas, and community health programs all encounter deinstitutionalized psychiatric patients. Frustration is common when nurses watch patients deteriorate to the point of becoming harmful to themselves or others before they are accepted back into the mental health system.

Slavinsky reported that during the period of implementation of deinstitutionalization, psychiatric nurses have been "largely out of the picture, at least as far as influencing the mental health care system was concerned."[8] Patients and nurses have suffered from psychiatric nursing's powerlessness in the health policy arena.

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In the final analysis, deinstitutionalization must be viewed as an example of health policy that, although attractive to both liberals and conservatives, has failed to provide the quality of care envisioned by the architects of the Community Mental

Health Movement. An analysis of the Massachusetts experience documented the power of corporate actors in determining mental health policy.

Psychiatric nurses are in a key position to help design systems of care that can provide quality care for the chronically mentally ill. Such a system requires a continuum of services ranging from acute inpatient care to community residences and respite care programs that can provide relief for families who care for their chronically mentally ill relatives.

Despite public outcry over increasing numbers of mentally ill homeless people, deinstitutionalization will probably continue. The Massachusetts program described in 1981 is partially implemented. The New York State Office of Mental Health recently announced a "reconfiguration of services" that would move an additional 7,000 people out of state hospitals in the next ten years even though the inpatient census has already dropped from 93,000 to 20,000.[13]

An opportunity exists for psychiatric nursing to become a corporate actor with influence on health policy. Visionary leaders and nurse researchers should join forces to design and evaluate model treatment and case management programs that would justify transferring some of the two thirds of public mental health dollars currently budgeted to hospitals to true community-based programs for the mentally ill.

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