

Deinstitutionalisation

Authored by
mohammad looti

November 19, 2022

RECOMMENDED CITATION

mohammad looti (2022). *Deinstitutionalisation*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=39232>

Deinstitutionalisation is the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with mental disorder or developmental disability. Deinstitutionalisation can have two definitions. The first definition focuses on reducing the population size of mental institutions. This can be accomplished by releasing individuals from institutions, shortening the length of stays, and reducing both admissions and readmission. The second definition refers to reforming mental hospitals' institutional processes so as to reduce or eliminate reinforcement of dependency, hopelessness, learned helplessness, and other maladaptive behaviors.

According to psychiatrist and author Thomas Szasz (1920-present), deinstitutionalisation is the policy and practice of transferring homeless, involuntarily hospitalized mental patients from state mental hospitals into many different kinds of de facto psychiatric institutions funded largely by the federal government began in the United States and was quickly adopted by most Western governments. The plan was set in motion by the Community Mental Health Act, passed by Congress in 1963, mandating the appointment of a Commission to make recommendations for "combating mental illness in the United States" (Thomas Szasz, 'Coercion as Cure', p.34).

In many cases, the mass deinstitutionalisation of the mentally ill in the Western world from the 1960s onwards has translated into policies of "community release". Individuals who previously would have been in mental institutions are no longer supervised by health care workers.

Origins

The 19th century saw a large expansion in the number and size of asylums in Western industrialized countries. Although initially based on principles of moral treatment, they became overstretched, non-therapeutic, isolated in location, and neglected in practice.

20th century

By the beginning of the 20th century, ever-increasing admissions had resulted in serious overcrowding. Funding was often cut, especially during periods of economic decline, and during wartime, in particular, many patients starved to death. Asylums became notorious for poor living conditions, lack of hygiene, overcrowding, ill-treatment, and abuse of patients.

The first community-based alternatives were suggested and tentatively implemented in the 1920s and 1930s, although asylum numbers continued to increase up to the 1950s. The movement for deinstitutionalisation came to the fore in various countries in the 1950s and 1960s.

The prevailing public arguments, time of onset, and pace of reforms varied by country. Class action lawsuits in the United States, and the scrutiny of institutions through disability activism and

antipsychiatry, helped expose the poor conditions and treatment. Sociologists and others argued that such institutions maintained or created dependency, passivity, exclusion and disability, causing people to be institutionalized.

There was an argument that community services would be cheaper. It was suggested that new psychiatric medications made it more feasible to release people into the community.

A key text in the development of deinstitutionalisation was *Asylums* by Erving Goffman.

Groups such as mental health professionals, public officials, families, advocacy groups, public citizens, and unions held differing views on deinstitutionalisation, however.

Consequences

Community services that developed included supported housing with full or partial supervision, and specialized teams (such as assertive community treatment and early intervention teams) in the community. Costs have been reported to be generally the same as for inpatient hospitalization, or lower in some cases (depending on how well or poorly funded community alternative are). Some regions introduced laws enabling the forced medication in the community of those with psychiatric diagnoses.

Although deinstitutionalisation has been positive for the majority of patients, it has severe shortcomings.

Expectations that community care would lead to fuller social integration were not achieved; many remain without work, have limited social contacts and often live in sheltered environments.

New community services were often uncoordinated and unable to meet complex needs. Services in the community sometimes isolate the mentally ill within a new ghetto, where service users meet each other but have little contact with the rest of the community. It has been said that instead of "community psychiatry", reforms established a "psychiatric community".

Existing patients were often discharged without sufficient preparation or support. A greater proportion of people with mental disorders became homeless or went to prison. Widespread homelessness occurred in some states in the USA and some other countries. Families can often play a crucial role in the care of those who would typically be placed in long-term treatment centers; however, many mentally ill people are resistant to such help, due to the nature of their conditions. The majority of those who would be under continuous care in long-stay psychiatric hospitals are paranoid and delusional to the point that they refuse help and do not believe they need it, which makes it difficult to treat them.

Moves to community living and services led to various concerns and fears, from both the

individuals themselves and other members of the community. Over a quarter of individuals accessing community mental health services in a US inner-city area are victims of at least one violent crime in a year, a proportion eleven times higher than the inner-city average.

The proportion is many times greater in every category of crime, including rape/sexual assault, other violent assaults, and personal and property theft. The rates are similar in those with developmental disabilities.

Despite perceptions by the public and media that people with mental disorders released into the community are more likely to be dangerous and violent, a large study indicated that they were no more likely to commit violence than those in the neighborhoods (usually economically deprived and high in substance abuse and crime) to which they typically moved.

Findings on violence committed by those with mental disorders in the community have been inconsistent and related to numerous factors; a higher rate of the most serious offenses such as homicide has sometimes been found but, despite high-profile homicide cases, the evidence suggests this has not increased over the period of deinstitutionalisation. Aggression and violence that does occur, in either direction, is usually within families rather than between strangers.

Deinstitutionalisation and the status of psychiatric institutions around the world

Asia

In Japan, the number of hospital beds has risen steadily over the last few decades.

In Hong Kong, a number of residential care services such as half-way houses, long-stay care homes, supported hostels are provided for the discharged patients. In addition, a number of community support services such as Community Rehabilitation Day Services, Community Mental Health Link, Community Mental Health Care, etc. have been launched to facilitate the patients to re-integrate into the community.

New Zealand

New Zealand established a reconciliation initiative in 2005 in the context of ongoing compensation payouts to ex-patients of state-run mental institutions in the 1970s to 1990s. The forum heard of poor reasons for admissions; unsanitary and overcrowded conditions; lack of communication to patients and family members; physical violence and sexual misconduct and abuse; inadequate complaints mechanisms; pressures and difficulties for staff, within an authoritarian psychiatric hierarchy based on containment; fear and humiliation in the misuse of seclusion; over-use and abuse of ECT, psychiatric medication and other treatments/punishments, including group therapy, with continued adverse effects; lack of support on discharge; interrupted lives and lost potential;

and continued stigma, prejudice and emotional distress and trauma.

There were some references to instances of helpful aspects or kindnesses despite the system. Participants were offered counseling to help them deal with their experiences, and advice on their rights, including access to records and legal redress.

Africa

Uganda has one psychiatric hospital.

Europe

Countries where deinstitutionalisation has happened may be experiencing a process of "re-institutionalisation" or relocation to different institutions, as evidenced by increases in the number of supported housing facilities, forensic psychiatric beds and rising numbers in the prison population.

Some developing European countries still rely on asylums.

Italy

Italy was the first country to start deinstitutionalisation of mental health care and to develop a community-based psychiatric system. The Italian example originated samples of effective and innovative service models and paved the way for deinstitutionalisation of mental patients. In 1978, the passing of Basaglia Law had started Italian psychiatric reform that terminated with the very end of the Italian state mental hospital system in 1998. The reform was directed towards the gradual dismantling of the psychiatric hospitals and required a comprehensive, integrated and responsible community mental health service.:665 The object of community care was to reverse the long-accepted practice of isolating the mental ill in large institutions, to promote their integration in the community offering them a milieu which is socially stimulating, while avoiding subjecting them to too intense social pressures.:664

North America

United States

The United States has experienced two waves of deinstitutionalisation. Wave 1 began in the 1950s and targeted people with mental illness. The second wave began roughly 15 years after and focused on individuals who had been diagnosed with a developmental disability (e.g. mental retardation). Although these waves began over 50 years ago, deinstitutionalisation continues today; however, these waves are growing smaller as fewer people are sent to institutions.

The social forces that have led to a move for deinstitutionalisation are many. However, researchers

generally speak of six main factors including: criticisms of public mental hospitals, incorporation of mind-altering drugs in treatment, support from President Kennedy for federal policy changes in the treatment for those with mental illnesses, shift to community based care, change in public opinion of those with mental disabilities, and state's desire to reduce cost of mental hospitals.

Criticisms of public mental hospitals

The public's awareness of the conditions of mental institutions began to increase during World War II (WWII). During this period, conscientious objectors (COs) were assigned to alternative positions, in which there were manpower shortages. About 2,000 were assigned to fill job positions in mental institutions that were understaffed. Upon witnessing the inadequate facilities, many of the COs got an expose in Life magazine in 1946 about the shockingly awful conditions of many of these mental hospitals. This expose would just be one of the first featured articles about the quality of mental institutions. Following WWII, articles and exposes about the mental hospital conditions would bombard popular and scholarly magazines and periodicals. In 1946, COs featured in the Life expose would form the National Mental Health Foundation, which was successful at convincing states to increase funding for mental institutions via public opinion support. Just 5 years later, the National Mental Health Foundation would merge with the Hygiene and Psychiatric Foundation to form the National Association of Mental Health.

Another revelation during WWII relevant to deinstitutionalisation was the epidemiological finding that 1 out of 8 men considered for military service for WWII was rejected based on neurological or psychiatric basis. These findings led to increased knowledge that mental illness was moderately prevalent. More importantly, people began to realize that cost that would be associated with more individuals being admitted to mental institutions (i.e. cost of lost productivity and mental health services).

This time period could also be characterised as the beginning in the change of public and congressional attitudes toward the mentally ill. Since many individuals suffering from mental illness had served in the military, many began to think that more knowledge about mental illness and better services could benefit the brave men that served as well as the nation as a whole. Moreover, Congress passed the National Mental Health Act of 1946, which created the National Institute of Mental Health (NIMH). The NIMH was pivotal in funding health research that would be essential in developing the mental health field.

The role of pharmacotherapy and deinstitutionalisation

During the 1950s many new drugs became available and incorporated into therapy for the mentally ill. These new drugs were effective in reducing severe symptoms, which would allow people with mental illnesses to live in communities ranging from their own homes to half-way houses to nursing

homes, etc. Drug therapy was not only quintessential for the depopulation of mental institutions, but it also opened opportunities for employment of the mentally ill.

President Kennedy's Support of Policy Change

In 1955 the Joint Commission on Mental Health and Health was authorised to investigate problems related to the mentally ill. After winning the 1960 election President John F. Kennedy took a special interest in the issue of mental health because his sister Rosemary was mentally disabled. Shortly after his inauguration, Kennedy appointed a special "President's Panel of Mental Retardation". The panel included professional and leaders of the organization. In 1962, the panel published a report with 112 recommendations to better serve the mentally ill. In conjunction with the Joint Commission on Mental Health and Health, The Presidential Panel of Mental Retardation and Kennedy's influence, two important pieces of legislation were passed in 1963: The Maternal and Child Health and Mental Retardation Planning Amendments and the Mental Retardation Facilities and Community Mental Health Centers Act. The first piece of legislation increased funding for research that focused on prevention methods of retardation. The second piece of legislation provided funding for community facilities that serve people with mental disabilities. Both of these Acts furthered the process of deinstitutionalisation.

The shift to community based mental health care

In general, professionals, civil rights leaders, and humanitarians saw the shift from institutional confinement to local care as the appropriate approach. The Deinstitutionalization Movement started off slowly but gained momentum as it adopted the philosophy of the Civil Rights Movement. During the 1960s, deinstitutionalisation decreased dramatically as the average length of stay decreased by more than half. Instead of placing people with mental illnesses in long term institutions, many began to be placed in community care facilities where they could get care for their mental health needs. Thus, the deinstitutionalisation that took place in the United States was more of a "transitionalisation", that is a transition from a mental institution to a more human community centered facility.

Changing public opinion of the mentally ill

Although public opinion has increased in favor for the mentally ill, mental disability is still stigmatised. As a result, advocacy movements in support of mental health emerged. These movements focus on reducing stigma and discrimination and increasing support groups and awareness. Another notable movement, the consumer or ex-patient movement began as protests in the 1970s. Many of the participants were actually ex-patients of mental institutions who were inspired to challenge the system's treatment of the mentally ill. Initially, this movement targeted

issues surrounding involuntary commitment, use of electroconvulsive therapy (ECT) and antipsychotic medication, and coercive psychiatry. The Liberation of Mental Patients, Project Release, and Insane Liberation Front were all examples of consumer movements and organisations. Many of these advocacy groups were successful in judiciary system. In fact, the United States Court of Appeals for the First Circuit ruled in favor of the Mental Patient's Liberation Front in the case of Rogers vs. Okin. This established the notion that patients had the right to refuse treatment. Another notable group, the National Alliance for the Mentally Ill (NAMI), was very successful in its lobbying efforts to improve services and gain equality of insurance coverage for mental illnesses. In fact, President Bill Clinton signed the Mental Health Parity Act of 1996 allowing the NAMI to reach its goal on the insurance coverage issue.

Government's desire to reduce cost and spending on hospitalisation

As hospitalisation costs increased due to improvements advocated by civic groups, both the federal and state governments were motivated to find less expensive alternatives to hospitalisation. Moreover, the 1965 amendments to Social Security shifted about 50 percent of the mental health care costs from the states to the federal government. This motivated the government to promote deinstitutionalisation. With the government on the side of deinstitutionalisation, getting legislation passed proved less difficult and problematic.

A number of factors led to an increase in homelessness, including macroeconomic shifts, but observers also saw a change related to deinstitutionalisation. Studies from the late 1980s indicated that one-third to one-half of homeless people had severe psychiatric disorders, often co-occurring with substance abuse.

A process of indirect cost-shifting may have led to a form of "re-institutionalisation" through the increased use of jail detention for those with mental disorders deemed unmanageable and noncompliant. Indeed, when laws were enacted requiring communities to take more responsibility for mental health care, funding to facilitate this could be absent, resulting in jail as the default option, with jails long documented as cheaper than psychiatric care. In Summer 2009, author and columnist Heather Mac Donald stated in City Journal, "jails have become society's primary mental institutions, though few have the funding or expertise to carry out that role properly... at Rikers, 28 percent of the inmates require mental health services, a number that rises each year."

South America

In several South American countries, the total number of beds in asylum-type institutions has decreased, replaced by psychiatric inpatient units in general hospitals and other local settings.