Deinstitutionalization: Its Impact on Community Mental Health Centers and the Seriously Mentally Ill

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Abstract

Deinstitutionalization has had a significant impact on the mental health system, including the client, the agency, and the counselor. For clients with serious mental illness, learning to live in a community setting poses challenges that are often difficult to overcome. Community mental health agencies must respond to these specific needs, thus requiring a shift in how services are delivered and how mental health counselors need to be trained. The focus of this article is to explore the dynamics and challenges specific to deinstitutionalization, discuss implications for counselors, and identify solutions to respond to the identified challenges and resulting needs.

State run psychiatric hospitals have traditionally been the primary component in the treatment of people with severe and persistent mental illness. For many years, individuals with severe mental illness (SMI) were kept out of the community setting. This isolation occurred for many reasons: a) the attitude of the public about people with mental illness, b) a belief that the mentally ill could only be helped in such settings, and c) a lack of resources at the community level (Patrick, Smith, Schleifer, Morris & McClennon, 2006). However, the institutional approach was not without its problems. A primary problem was the absence of hope and expectation that patients would recover (Patrick, et al., 2006). In short, institutions seemed to become warehouses where mentally ill were kept for long periods of time with little expectation of improvement.

In 1963, the Kennedy administration addressed the institutionalization of the severely mentally ill and the condition of state mental hospitals. The result was the passage of the 1963 Community Mental Health Centers Act (CMHCA). The CMHCA had a tremendous impact on the mental health system in the United States and upon the profession of mental health counseling. This act not only restructured how services were provided but also who performed those services. No longer was treatment restricted to the medical professionals. Therapeutic services to the SMI were now relegated to a host of non-medical professionals.

Previous to the CMHCA, mental health counselors were primarily working with people who were struggling with issues such as marital conflict or developmental issues, but who were essentially healthy (Browers, 2005). Individuals with SMI, especially if it were persistent, were placed in hospitals and dealt with at the institutional level. However, the development of the first antipsychotic medication in 1954 opened the door for community-based treatment rather than lifelong institutionalization (Stubbs, 1998). The CMHCA legislation brought people into the community who exhibited more significant symptoms of mental illness, thus creating new challenges for the mental health system at the community level, as well as for mental health counselors.

Social, Cultural, and Political Context of the Deinstitutionalization

It should not be surprising that such a dramatic shift in approach for treating individuals with SMI should emerge from the culture of the 1960's. The culture was distinct from the conservative lifestyle of the fifties and there was a revolution of thought and a radical shift in the framework of American life. This was a time

when the rights of individuals became highly valued, with both the civil rights movement and the feminist movement attacking beliefs and values that oppressed and limited populations (Goodwin, 2005). Goodwin suggested this was also a time dominated by youth, with the baby boomer generation moving into its teen years and young adulthood. This generation was shaped by powerful events including the war in Vietnam, the Civil Rights movement, women's liberation, the hippie movement, a newly emerging environmental movement, and even the space race (Dixon & Goldman, 2003; Goodwin, 2005). It seems a logical conclusion in the midst of this rush toward positive social change that the plight of the mentally ill should get some attention and that an institutional approach to treatment should be challenged (Feldman, 2003).

It should be noted that this era was also a time when, at the political level, a great deal of change was occurring. John F. Kennedy was a charismatic leader who created much hope in America (Goodwin, 2005). President Kennedy seemed prepared to involve the government in social change. The CMHCA was a reflection of the political climate present during the days of the Kennedy administration (Dixon & Goldman, 2003; Feldman, 2003). The change occurring in mental health at the political level had actually begun during World War II, but culminated with the Joint Commission on Mental Health and Illness. After eight years of examination, the Commission submitted a report which indicated that the nation needed to become less dependent upon hospitals and more dependent on non-traditional caregivers such as case workers, clergy and educators. This perspective was a significant factor leading to the CMHCA three years later (Feldman, 2003).

Challenges of Deinstitutionalization

The benefits of deinstitutionalization have been noted in the professional literature. These benefits have been identified as independence and a better quality of life outside of institutions (Forrester-Jones et al., 2002), reduction in psychotropic medication needs (Hobbs, Newton, Tennant, Rosen & Tribe, 2002), and increased socialization and adaptability to change (Priebe, Hoffman, Isermann, & Kaiser, 2002). However, Iodice and Wodarski (1987) contended that while in theory it may have been a good idea, it may not have worked as well as intended. The individuals who were to receive the benefits of deinstitutionalization were often homeless, isolated, and victimized. Some individuals with SMI who were released from institutions deteriorated, were reinstitutionalized, and some lost their lives (Honkonen, Henriksson, Kovisto, Stengard, & Salokangas, 2004; Iodice & Wodarski, 1987; Kelly & McKenna, 2004; Sealy & Whitehead, 2004).

Kelly and McKenna (2004) suggested that the community at large is frequently afraid of people with mental illness, believing them to be dangerous. This belief often caused rejection, stigmatization, victimization, and harassment (French, 1987). Mentally ill clients thus become unsupported and at high risk for self harm. Instead of being integrated into the community, people with mental illness traded the isolation of the hospital for the isolation of the house or apartment (Kelly & McKenna, 2004). In a recent study, it was concluded that individuals with SMI were victims of violent crime at a rate 11 times higher than that of the general population (Teplin, 2005). An additional challenge that resulted from deinstitutionalization was the incarceration of individuals with SMI. A study investigating the relationship between deinstitutionalization and homelessness and crime found a statistically significant correlation between deinstitutionalization and homelessness, and a more pronounced correlation between homelessness and criminal activity (Markowitz, 2006). Of the state and federal prison populations, as well as county jails, roughly 15-22% of individuals incarcerated have psychotic disorders, compared to 3.1% of the general population (James & Geize, 2006). In as much as 66% of these cases, these individuals have served prior sentences. Further, only one in three of these inmates report receiving mental health treatment while incarcerated. These statistics indicate a different setting for a similar institutionalization. When not incarcerated, these individuals are twice as likely to be homeless (James & Geize, 2006). It seems, then, that deinstitutionalization, while providing freedom, has not solved the problem of providing needed mental health services.

Implications for Mental Health Counseling

Clearly the CMHCA necessitated the movement of care from a state institution into the community. This means that communities are being asked to absorb individuals with SMI into the community setting, a reality that has many implications. This move necessitates not only the development of appropriate housing, but also the development of psychiatric, therapeutic, case-management, health and educational services to provide the wrap-around care needed by this population (Hobbs, et al., 2001; Patrick, et. al, 2006; Pruett, Davidson, McMahon, Ward & Griffith, 2000; Werner & Tyler, 1993). The major challenge for community mental health centers is limited funding to support mental health professionals that provide more specific and in-depth services to the SMI population. As indicated in a recent article in Clinical Psychiatry News (Johnson, 2006), community mental health centers are currently understaffed and face increased understaffing.

All of the discussion regarding whether the CMHCA was positive or negative may well depend upon whether one believes the goal is to keep clients stable in the community (i.e., maintenance) or whether it is to help the clients learn and grow (i.e., recovery). The National Institute of Mental Health in England (NIMHE, 2005) focuses on recovery as a process of returning to a state of wellness. The goal is to help individuals with SMI discover optimum quality and satisfaction with life. It is a personal process of overcoming the negative impact of diagnosed mental illness/distress despite its continued presence. In order to facilitate recovery, NIMHE focuses on nine essential components including a) clinical care, b) family support, c) peer support, d) work and meaningful activity, e) personal power and control, d) community involvement, education, e) access to resources that promote recovery (e.g., such as technologies), and f) the minimization of stigma attached to mental illness. Most of these components require an intervention from a community based setting. The CMHCA clearly creates impetus for the adoption of a recovery model.

With a shift in treatment setting and paradigm, it has become important to develop treatment programs that are effective for the SMI in the community setting. As indicated above, certain key elements have been identified as being important and new evidence-based practices have emerged (Dixon & Goldman, 2003; Rogers, 2003). It should be noted that many of the evidence-based practices related to working with people who have SMI in the community require multi-disciplinary approaches and people with various levels of training (Feldman, 2003; Forrester-Jones, et. al., 2002; Iodice & Wodarski, 1987). This has increased the need for counselors and possibly has contributed to the expansion of the role of providers with master's degrees. It is simply impossible to adequately provide therapy to the SMI population with the limited numbers of psychiatrists and psychologists available.

There has been some initial research related to various approaches that are effective when working with people having SMI in the community setting. One of the most successful of these approaches is Assertive Community Treatment, in which a multidisciplinary team works with clients who have SMI in their natural setting (e.g., home, work; ACTA, 2007; Marsh, 2006). This model has demonstrated effectiveness as a meta-analysis found that in randomized trials those subjects with whom assertive community treatment was used were less likely to become homeless and had improvement in symptom severity compared with those who were part of more standard treatment protocols (i.e., standard case management). Peer-support models (i.e., peer support counseling) have also been found to be effective (Davidson, 2006; Hardiman & Segal, 2003; Shahar, Kidd, Styron, & Davidson, 2006). In addition, supportive employment models are noted to provide benefit to the SMI population in that not only are the services effective but those providing the services gain a sense of intrinsic reward and satisfaction for their efforts. From a practical perspective, it was found that the cost of providing mental health care is reduced for those who receive supported employment. Further, the number of hours of mental health services provided per month for these same individuals was almost cut in half (Becker, Drake & Naughton, 2005; Perkins, Born, & Raines, 2005).

In addition, the movement of care into the community setting resulted in a need for many professionals working at the community level to receive additional training, including specific skills for working with the SMI population. Thus, continuing education and master's level counselor training was needed to teach skills that enable counselors to work with this population (Feldman, 2003). However, in a review of counselor training program plans of study, as specified on program homepages, no courses were provided specific to the SMI

population. Thus, it can be assumed that many counselor training programs address the SMI population is abnormal behavior or diagnosis and assessment coursework only.

The Campaign for Mental Health Reform (CMHR) is supported by 16 organizations, including National Alliance for the Mentally Ill, the National Mental Health Association, and others (CMHR, n.d.). This reform recommends increased federal and state funding for a) Community Mental Health Centers, b) programs for prevention, early intervention, and rehabilitation services for SMI, and c) discharge planning and links to mental health services upon release from jail or prison. Further, increased funding is needed to meet the requirements of the Mentally Ill Offender and Treatment Crime Reduction Act of 2004 (P.L. 108-414), which supports provision of services within the criminal justice and mental health systems. I am not quite sure what to make of this, especially the parentheses. My best guess is that a citation and reference are missing? The CMHR provides a response to the challenges outlined above and would allow for the full intentions of deinstitutionalization and CMHCA to be realized.

Conclusion

Deinstitutionalization and the CMHCA initiated in 1963 has had a profound effect upon the counseling profession. While it has encouraged the development of the profession, it has also provided the profession with new challenges. Counselors have been forced to respond to the need to gain new competencies and encourage collaborative relationships with other mental health providers. The biggest challenge remains with the funding of programs to support the continued deinstitutionalization of those with SMI, although from the institution of imprisonment rather than psychiatric hospitalization. Mental health services for those individuals with SMIs who are incarcerated need to be improved, including an aftercare component once released from jail or prison.

Any failures related to deinstitutionalization are not the result of philosophical errors but rather the implementation of models designed to support individuals with SMI (Talbott, 2004). Specifically, the lack of funding limits the efficacy of such models. Increased funding can provide new and established services to further support deinstitutionalization. Additionally, increased funding can provide more employment opportunities for counselors to work with the SMI population, thus allowing for more manageable numbers of SMI clients on caseloads. Thus, through adequate funding existing services can be improved, training specific to working with the SMI population can be provided, and the opportunity for new and more effective programs can be offered.

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