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HELMS SCHOOL OF GOVERNMENT

The Impact of the Deinstitutionalization Policies on Homelessness

by

Henrique Krigner Laino
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PROBLEM: The deinstitutionalization policies are a direct source of homelessness in America.

Problem Overview

Initiated in the 1950s by President John F. Kennedy and concluded by President Ronald Reagan, the deinstitutionalization movement gathered massive civil approval to endorse the shutting down of mental hospital facilities in America and disincentivize the creation of new ones by state governments. The movement gained grounds among the public by reporting cases of inalienable rights violations in these institutions and by defending alternative treatments that should be enough to reinsert the mentally ill into American society. However, the community-based approach never delivered the promised results, leading thousands of patients to be homeless or institutionalized in inadequate facilities and dependent on substance abuse as an alternative treatment.

As further explained in the following sections, the deinstitutionalization movement resulted in another social phenomenon known as trans-institutionalization[1].

Trans-institutionalization is the process whereby individuals with mental illness are accepted into institutions such as prisons, hospitals, nursing homes, and homeless shelters due to the lack of proper public care for the mentally ill[2]. Such institutions are not equipped to treat the mentally ill properly, delivering poor treatment at a higher expense. In 2017, 44% of the United States incarcerated population was diagnosed with some mental disorder[3]. In the same year, about 30% of the United States homeless population (sheltered and unsheltered) had a severe mental illness disorder. This share can grow to 70% in cities where homelessness is rapidly increasing.

Impacts

With the deinstitutionalization policies, mental health patients were left to be cared for by family, friends, or themselves. The ones who had no home to return to found shelter on the streets, initiating a vicious cycle of governmental dependence, crime, and, potentially, addiction.

The first impact to be considered is the influx of the mentally ill into homelessness. About a third of the homeless population in the United has a severe or moderate mental illness[4]. The U.S. Department of Housing and Urban Development classifies them as “chronic homeless” with a low likelihood of recovery and social reintegration[5]. Most federally funded housing initiatives, such as the Housing First program, are targeted to the chronically homeless as

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[1] Ashley Primeau et al., “Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions,” *Comprehensive Psychology* 2 (January 1, 2013): 16.02.13.CP.2.2, https://doi.org/10.2466/16.02.13.CP.2.2.

[2] “Transinstitutionalization | Encyclopedia.Com,” accessed November 29, 2022, https://www.encyclopedia.com/social-sciences/dictionaries-thesauruses-pictures-and-press-releases/transinstitutionalization.

[3] Jennifer Bronson, “Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12,” 2017, 17.

[4] “2019 Point in Time Estimates of Homelessness in the U.S.,” HUD.gov / U.S. Department of Housing and Urban Development (HUD), December 20, 2019, https://www.hud.gov/2019-point-in-time-estimates-of-homelessness-in-US.

[5] HUD, “Criteria and Recordkeeping Requirements for Definition of Homelessness,” HUD Exchange - At a Glance (Department of Housing and Urban Development, n.d.), https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf.

immediate assistance to prevent further harm and position them on a journey to recovery[6]. However effective this immediate care may be, it still is not comparable to the proper psychiatric treatment.

Secondly, there is a high cost of maintaining a person with mental disorders in institutions that are not properly equipped, such as jails or homeless facilities. While the average cost for psychiatric treatment in a community hospital may range from $3,616 to $8,509 depending on the type of treatment required[7], the cost of holding a person in federal custody is $102.60 per day per adult[8]. The cost of juvenile incarceration can be almost $600 per day per youth[9]. This means that sentencing an adult for any period longer than 35 days and a juvenile for longer than six days is already more expensive than providing proper psychiatric treatment with greater chances of recovery.

Another impact to be considered is the recidivism factor. In 2019, 27% of individuals arrested three times or more within one year had a severe or moderate mental illness[10]. This number is expected to be greater in locally run jails. Therefore, not providing the proper treatment can encourage recidivism, adding up to the costs and exposing the person to incarceration, lasting effects such as post-traumatic stress, anxiety, and impaired decision-making, making reinsertion into society even more complex and less likely.[11]

Finally, the fourth impact to be considered is that mentally ill individuals that do not have access to proper treatment pose a severe threat to society and themselves. One of the consequences of the deinstitutionalization movement was the rejection of involuntary treatment policies. This changed with the introduction of Assisted Outpatient Treatment (AOC) bills that allows court-ruled involuntary treatment to prevent an individual from further harm to self and others. AOC bills gained massive public support in the late 1990s and early 2000s after the murders of Laura Wilcox (C.A.) and Kendra Webdale (N.Y.). In both cases, the murderer was a mentally ill person who had previously refused proper treatment and committed the crimes during a breakout.

Root Causes

The deinstitutionalization movement gained public support and political momentum through the growing reports of human rights violations in mental hospitals, new psychiatric approaches to mental illness, and the release of new drugs, which promised to ensure a significant improvement in the quality of life of the mentally ill.

Stirred by reports on human rights violations in mental hospitals in Europe and the U.S. in the early 1960s[12], important names within the medical community pushed the agenda for

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[6] Adam Whisler et al., "The Effect of a Housing First Intervention on Primary Care Retention among Homeless Individuals with Mental Illness," ed. Adam T. Perzynski, *PloS One* 16, no. 2 (2021): e0246859–e0246859, https://doi.org/10.1371/journal.pone.0246859.

[7] Joseph Vanable, "The Cost of Criminalizing Serious Mental Illness | NAMI: National Alliance on Mental Illness," n.d., https://www.nami.org/Blogs/NAMI-Blog/March-2021/The-Cost-of-Criminalizing-Serious-Mental-Illness.

[8] "Annual Determination of Average Cost of Incarceration Fee (COIF)," Federal Register, November 19, 2019, https://www.federalregister.gov/documents/2019/11/19/2019-24942/annual-determination-of-average-cost-of-incarceration-fee-coif.

[9] "Annual Determination of Average Cost of Incarceration Fee (COIF)."

[10] Prison Policy Initiative, "Rates of Mental Illness and Substance Use Disorders Are Much...," accessed November 30, 2022, https://www.prisonpolicy.org/graphs/frequent_utilizers_mh_sud.html.

[11] Initiative.

[12] Primeau et al., "Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions."

deinstitutionalization. Thomas Szasz went further ahead, even to question if there was such a condition to be considered as mental illness. To him, mental illness is the term applied to refer to mental characteristics still unknown to science.[13] Therefore, mental health asylums were an instrument of social control that could only aggravate one's mental struggles.[14]

The advancement of psychotropic drugs also contributed to the belief that community-based centers would be more appropriate than mental asylums[15]. Chlorpromazine and Thorazine were drugs able to drastically reduce hallucinations, delusion, and disorganized thought associated with schizophrenia and other mental conditions. Eight months after its release, more than two million patients had received the drug,[16] raising the hope of social reintegration among psychiatrists and those related to the mentally ill. It was only in the late 1970s that reports on Chlorpromazine side effects and inefficiency in curing severe mental illness started to arise.[17] By then, two-thirds of the mental health population had already been released[18] , and the deinstitutionalization policies were very advanced.

Policy Alternatives

Community Mental Health Act of 1963

The Community Mental Health Act (CMHA), signed into law by President John F. Kennedy in 1963, is the first piece of legislation of the deinstitutionalization movement. It marked a significant change in the approach to the mentally ill, who were massively sent to asylums and secluded from social interaction. Among its primary contributions, the CMHA destinated funds for the building and staffing 1500 community mental health centers. These centers relied on the expected efficiency of newly released medications to treat the mentally ill. They were designed to provide five essential services: consultation and education for community and professional organizations, inpatient facilities, outpatient clinics, emergency response, and partial hospitalization.

Because states had no assurance of long-term funding, only half of the community mental health centers initially planned by the CMHCA were built. Even so, with the redirection of funds, the mental hospital population decreased by 90% over the next four decades. The care for the mentally ill fell back on families. Those without a family or a home entered the cycle of institutional acute care hospitals, jails, and prisons.

Mental Health Systems Act of 1980

The Mental Health Systems Act (MHSA) was signed into law by President Jimmy Carter, providing grants to community mental health centers to incentivize states to build more centers

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[13] Thomas Szasz 1920-2012, *The Myth of Mental Illness : Foundations of a Theory of Personal Conduct* (Revised edition. New York : Harper & Row, [1974] ©1974, 1974), https://search.library.wisc.edu/catalog/999477096002121.

[14] Matthew Smith, "Deinstitutionalization and After | Psychology Today," accessed December 1, 2022, https://www.psychologytoday.com/us/blog/short-history-mental-health/201305/deinstitutionalization-and-after.

[15] William Gronfein, "Psychotropic Drugs and the Origins of Deinstitutionalization," Social Problems (Oxford University, June 1985), https://www.jstor.org/stable/800774#metadata_info_tab_contents.

[16] M Rosembloom, "Chlorpromazine and the Psychopharmacologic Revolution" 287, no. 14 (April 10, 2002): 1860–61, https://doi.org/10.1001/jama.287.14.1860.

[17] Rosembloom.

[18] Rosembloom.

and thus match the demand for mental health treatment.[19] The MHSA was primarily repealed in 1981 by President Reagan's Omnibus Budget Reconciliation Act of 1981.

Omnibus Budget Reconciliation Act of 1981

President Reagan signed the Omnibus Budget Reconciliation Act (OBRA) into law, repealing most of the MHSA. Its primary purpose was to consolidate the funding related to mental health and substance abuse programs into block grants giving states autonomy to administer their allocated funds[20]. With OBRA enacted, the federal government ended its responsibility to care for the mentally ill. While providing more independence to the State governments, the OBRA also cut 30% of the federal funding to mental health care[21].

The 1963 CMHA signed by President Kennedy is the landmark of the deinstitutionalization movement. Likewise, the 1981 OBRA signed by President Reagan is seen as the final initiative that culminated in the shutting down mental hospitals and asylums, disabling court-ruled interventions.

Constitutional Guidelines

The Constitution of the United States does not explicitly address the issue of mental illness nor attribute to the State the responsibility of providing treatment.[22] This goes against an international trend stimulated by the United Nations Declaration of Human Rights of 1948, in which the treatment of mental illness was classified as a human right to be preserved by the State.[23] Most of the developed nations quickly acted to adopt that same classification in their legal codes and organize a State-sponsored approach to mental illness.[24]

Throughout the years, the American Supreme Court and Congress have adopted different understandings of the role of the State in mental illness treatments. The ones in favor of providing State-sponsored therapy to the mentally ill argue that mental illness directly threatens the right to pursue life, liberty, and happiness. And by ensuring treatment, the U.S. government would be protecting this inalienable right.[25]

The ones against the claim that the State should not be trusted to decide upon a person's mental capacity nor to provide State-sponsored treatment.[26] To them, a State-sponsored mental treatment facility could be eventually used as punishment, thus violating the Eighth Amendment to the Constitution of the United States.[27]

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[19] "Mental Health Systems Act," Pub. L. No. Public Law 96-398, § Volume 94, 1564 (1980), https://www.govinfo.gov/app/details/STATUTE-94/STATUTE-94-Pg1564/summary.
[20] "National Institute of Mental Health (NIMH)," National Institutes of Health (NIH), July 9, 2015, https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh.
[21] Viern Pierson, "Hard Truths about Deinstitutionalization, Then and Now," *CalMatters*, March 10, 2019, http://calmatters.org/commentary/2019/03/hard-truths-about-deinstitutionalization-then-and-now/.
[22] Robert L. Trestman, "The Treatment of Mental Illness Is a Human Right," *Journal of the American Academy of Psychiatry and the Law Online* 46, no. 1 (March 1, 2018): 2.
[23] United Nations, "Universal Declaration of Human Rights," United Nations (United Nations), accessed December 5, 2022, https://www.un.org/en/about-us/universal-declaration-of-human-rights.
[24] Trestman, "The Treatment of Mental Illness Is a Human Right."
[25] Rob Whitley and Benjamin F. Henwood, "Life, Liberty, and the Pursuit of Happiness: Reframing Inequities Experienced by People with Severe Mental Illness," *Psychiatric Rehabilitation Journal* 37 (2014): 68–70, https://doi.org/10.1037/prj0000053.
[26] Bruce J. Winick and Lamont, "When Treatment Is Punishment: Eighth Amendment Limits on Mental Health and Correctional Therapy," May 1996, 211.
[27] "U.S. Constitution - Eighth Amendment | Resources | Constitution Annotated | Congress.Gov | Library of Congress," accessed December 5, 2022, https://constitution.congress.gov/constitution/amendment-8/.

Suggestions for Future Research

The data presented previously on the consequences of the deinstitutionalization movement suggests the need for an urgent review of the United States federal approach to mental illness. The human rights violations committed in the past and the institutional structures that covered them for so long are not to be allowed or repeated ever again. However, further research on the effectiveness of mental treatment for the mentally ill homeless population is required. The results could be compared to the ones obtained in homeless shelters and law enforcement facilities like prisons and jails, making the objective case for a legislation change at the federal level.

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