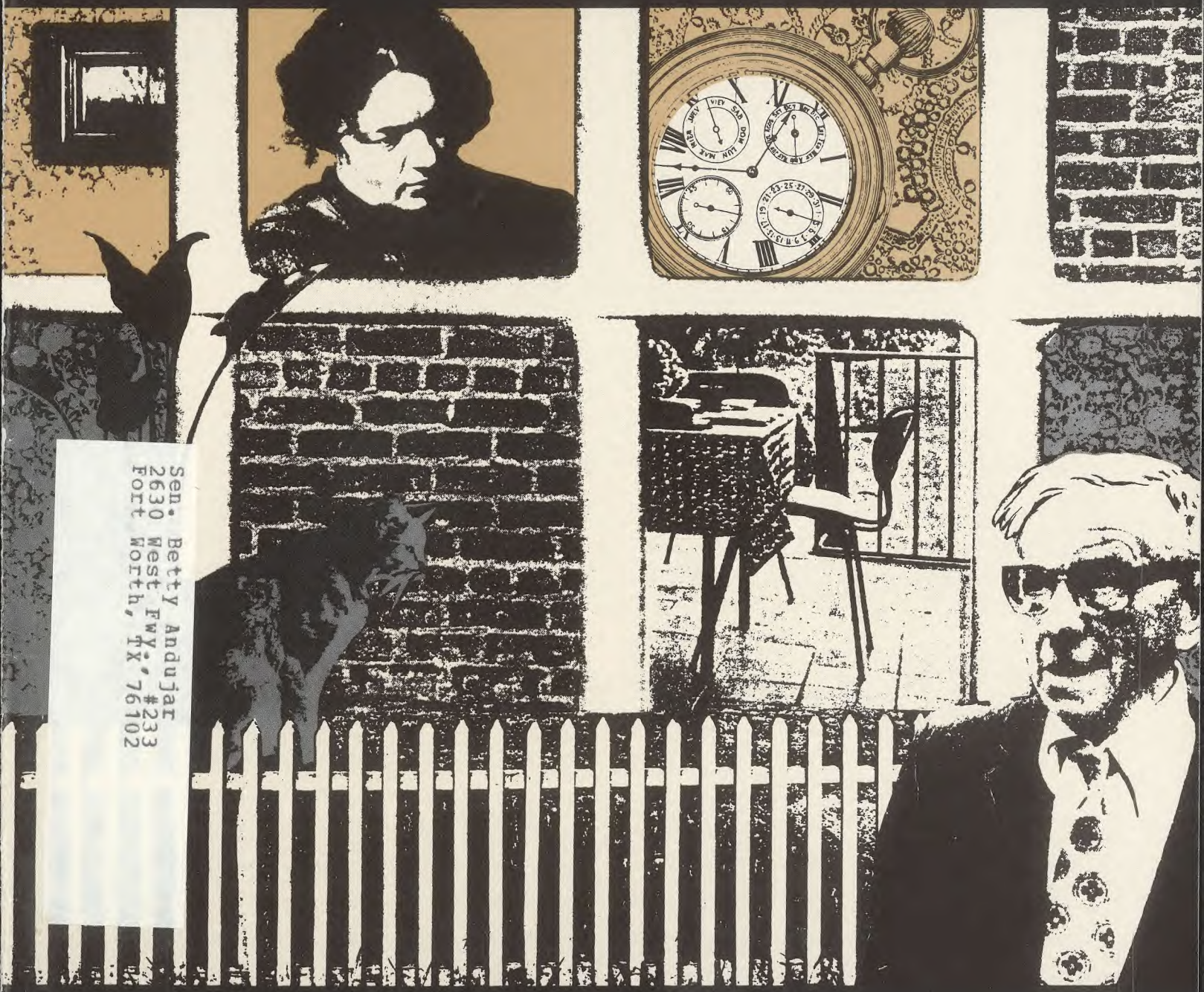
State Government News

The Council of State Governments

October 1980



Deinstitutionalization—Does It Work?

THE COUNCIL OF STATE GOVERNMENTS

EDITORIAL STAFF
Director of Communications:
Jack Gardner
Editor:
Elaine S. Knapp
Editorial Assistants:
Karen Haller
Jennifer Stoffel
Compositor:
Linda Bowman

State Government News

The monthly magazine covering all facets of state government.

October 1980 • Vol. 23 • No. 10

STATE GOVERNMENT NEWS—
Published monthly by The Council of State Governments, P.O. Box 11910, Lexington, Kentucky 40578. Considered the prime source of information on current activities by all branches of state government on a monthly basis. Articles cover new state laws, federal-state relations, and state legislative trends, as well as court decisions and administrative actions. Monthly features focus on topics of particular concern to states. Writers include headquarters and regional staff professionals. Opinions expressed in this magazine do not necessarily reflect the policy of the editorial staff or the Council of State Governments.

★ ★

Subscription rates—
In the U.S., $12 per year. Elsewhere, $20 per year. Single issues $1 per copy from the Circulation Department at the offices of *State Government News*. Change of address: Please send old and new addresses.

★ ★

Circulation—
Elizabeth Williams, Supervisor, Information Systems.

★ ★

Advertising—
James C. Toedtman, Director of Marketing and Sales; Patricia Dowling, Manager of Advertising; Edith Nealy, Advertising Sales Associate; Leslie Mulligan, Manager of Advertising Production. For advertising, rate information, and media data, call or write: Media Management, Inc., (Main office), 10 Beech St., Berea, Ohio 44017, (216) 243-8250; (Southern office) 202 East Bay St., Savannah, Georgia 31401, (912) 233-2270; or (Western office) 15431 Vassar St., Westminster, California 92683, (714) 898-1035.

★ ★

Readers' comments are welcome as are items on newsworthy state developments. Unsolicited editorial material and manuscripts will not be returned unless accompanied by stamped, self-addressed envelope.

★ ★

 Publication number: ISSN 0039-0119. Second-class postage paid at Lexington, Kentucky, with an additional entry at Hialeah, Florida. Postmaster: Send address changes to State Government News, *P.O. Box 11910, Lexington, Kentucky 40578.*

Cover art by Elaine Golob Weber

Index

About the Council of State Governments:
The Council of State Governments is a joint agency of all state governments—created, supported, and directed by them. It conducts research on state programs and problems; maintains an information service available to state officials and legislators; issues a variety of publications; assists in state-federal liaison; promotes regional and state-local cooperation; and provides staff for affiliated organizations.

HEADQUARTERS OFFICE: P.O. Box 11910, Iron Works Pike, Lexington, Kentucky 40578; (606) 252-2291.
EASTERN OFFICE 1500 Broadway, 18th Floor, New York, New York 10036; (212) 221-3630.
MIDWESTERN OFFICE 203 North Wabash Avenue, Chicago, Illinois 60601; (312) 236-4011.
SOUTHERN OFFICE: 3384 Peachtree Road, NE, Atlanta, Georgia 30326; (404) 266-1271.
WESTERN OFFICE: 165 Post Street, 5th Floor, San Francisco, California 94108; (415) 986-3760.
WASHINGTON OFFICE: Hall of the States, 444 North Capitol Street, Washington, D.C. 20001; (202) 624-5450.

Patients released to communities:

Deinstitutionalization—Does It Work?

BY DAVID E. SUMNER, CSG

Deinstitutionalization was hailed as a revolutionary advance in health care in the 1960s and early 1970s. Under the banner of "community-based care," an estimated 2 million people were released from mental hospitals and mental retardation and other long-term care facilities between 1955 and 1980. But now some officials and health authorities are asking, "Does it work?"

Deinstitutionalization has been tried for the retarded, the elderly in nursing homes, and juvenile delinquents, but its greatest impact has been on the treatment of the mentally ill. From 1955 to 1977 (latest available figures), the population in state mental institutions decreased from 560,000 to 157,000.

Several reasons account for this 72 percent reduction. First, psychotropic drugs have been effective in reducing patient symptoms. Second, it was thought that patients could be rehabilitated more successfully in a community setting. Third, court rulings affirmed legal rights of institutionalized persons, especially the right to treatment, and no longer permitted a merely custodial role for state mental institutions. Finally, administrators recognized that state governments would save money by releasing patients whose care could be paid for through various federal programs.

Photo: Public Broadcasting Service

DEINSTITUTIONALIZATION—*Pilgrim State Hospital on Long Island is one of the many mental institutions which has adopted the policy of deinstitutionalization and discharged its patients into the community. Photo is from a PBS documentary, "Ready or Not," which examined how patients are affected by their release into society.*

Opposition to Releases

Deinstitutionalization has been protested by many groups—citizens and hospital employees, as well as health officials. When Pennsylvania announced the closing of a state hospital in Wilkes-Barre in 1974, over 100,000 people from the area signed a petition denouncing the release of the patients. Wilkes-Barre residents blocked efforts to establish aftercare facilities in their neighborhoods three times in a period of four years.

When the mentally ill and retarded are released to communities, neighborhood groups often protest that property values will decrease, crime will increase, and the "character" of the neighborhood will be destroyed. Some estimate that half of all proposed community-based programs are blocked because of neighborhood opposition.

At least 15 states—Arizona, California, Colorado, Maryland, Minnesota, Montana, New Jersey, New Mexico, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and Wisconsin—have enacted legislation prohibiting housing discrimination against aftercare facilities for the mentally ill or retarded. These statutes vary, but the effect is to override local zoning ordinances.

The strongest and most cohesive opposition against deinstitutionalization comes from unions representing health care employees who fear loss of jobs. In a report issued by the American Federation of State, County, and Municipal Employees, author Henry Santiestivan says, "Health care workers have had too many negative experiences with deinstitutionalization as a shell game for budget cuts, layoffs and profiteering."

Problems Not Widespread

Harry C. Schnibbe, executive director of the National Association of State Mental Health Program Directors, says, "It's only a handful of eastern states—Pennsylvania, New York, Massachusetts, Ohio, and a couple of others—that have deinstitutionalization problems." He says that in these states

Photo: National Association for Mental Health

MENTAL HEALTH—*Shown is a worker in a hospital. Unions representing health care employees have been most vocal in opposing the release of patients to the community.*

there is enormous employee union and legislative resistance.

Schnibbe adds, "There is no deinstitutionalization in half the states." He explains that the most drastic hospital reductions have already been accomplished. Now hospitals are focusing on acute care, rather than chronic and custodial care.

One of the results of deinstitutionalization in mental hospitals has been an increase in the number of readmissions. According to the *Statistical Abstract*, in 1960 there were 2.3 admissions per 1,000 population in the U.S., but by 1978 this figure had increased to 3.1. This is mainly the result of readmissions.

One state that seems to be reversing its deinstitutionalization policies is Washington. Dr. Delbert Kole, director of Mental Health Services, says there was an increase in the number of state hospital patients this past year. He attributes this to stricter commitment laws enacted by the legislature. Kole says, "I do not expect a decrease in total hospital population in the foreseeable future."

Many states have been busy trying to meet court-imposed requirements regarding patient rights. It has not always been possible to systematically assess patient needs and design programs to meet those needs. "Psychiatric ghettos" in cities in New York and California have received wide publicity.

California was one of the early leaders in the deinstitutionalization movement. The state closed half of its 20 state hospitals between 1960 and 1980. In so doing, it established skilled nursing facilities (SNFs), intermediate care facilities, and private "board and care" homes throughout the state.

However, the SNFs have run into funding problems. The 1,400 SNFs admit patients in all medical categories, but the U.S. Department of Health and Human Services disallows federal funding in any such facility with more than 51 percent of its patients with mental disabilities. And according to Clifton Cole, chief deputy director of Health Services, "They use a very broad classification." As a result, many of the SNFs are losing or not qualifying for federal funding. Cole adds, "Proposition 13 has affected us tremendously."

In most states, community care has not kept up with the increase in patient releases from institutions and the patients' need for medical aid, counseling, housing, jobs, and economic aid. Most authorities agree that the deinstitutionalized should receive the same treatment and services as if housed in an institution.

Recent federal legislation should provide good news to state officials and a partial solution to these problems. The Mental Health Systems Act was passed by the U.S. House on August 22, after being passed earlier by the Senate. It provides grants for the chronically mentally ill served by community mental health centers, as well as grant money for the unserved and underserved populations.

U.S. Representative Henry Waxman (D-Calif.), sponsor of the bill, told *State Government News*, "Basically, the bill provides that before a community mental health center can be funded by the federal government, it will need state approval. It will allow states to play a greater role than they have in the development of community mental health centers."

Retarded Affected

Deinstitutionalization for the mentally retarded has been more successful in that it has often prevented inappropriate and ill-planned mass releases. There has been continued growth in intermediate-care facilities (ICFs) for the retarded. An increasing number of state institutions are seeking certification as ICFs so that they can receive federal funding.

A lower court in Pennsylvania sparked controversy by ruling that institutional care for the retarded violates the U.S. Constitution and ordering all 1,000 patients discharged from the state's Pennhurst Center. On June 20, the U.S. Supreme Court ordered those discharges halted until the court can decide whether to overturn or uphold the ruling. Six other states—Connecticut, Illinois, New Hampshire, New Jersey, New York, and Washington—are currently facing similar lawsuits that would totally close down their institutions for the retarded.

Despite the questions, most states are continuing deinstitutionalization programs. In 1979, Illinois began a five-year program for halving the population of its mental retardation facilities. Florida is beginning deinstitutionalization with pilot programs in three cities. Bill Buzogany, director of Mental Health Services for Wisconsin, says, "We have no movement towards reinstitutionalization. If so, it will be for economic reasons." Dr. Leo Kirvin, commissioner of mental health and retardation in Virginia, says, "Our trend is towards increasing deinstitutionalization."

Deinstitutionalization has created many unexpected problems in cities and states where it has been implemented. Because the problems of each state vary, it is difficult to make comparisons. While many people are asking, "Does it work?" most states continue to make it work. However, the major questions about deinstitutionalization in the 1980s will not be medical, social, or legal, but like everything else—dollars.