DEINSTITUTIONALIZATION OF INDIANA
STATE MENTAL HOSPITALS; A STAFF REPORT. 1977

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Preface

This staff report was developed to better understand the need for community residential services to "chronic" patients. The topic of deinstitutionalization is quite complex and this report reviews the social science literature on this topic and develops planning recommendations. Statistical data is also presented. Further research is needed into the various aspects of the deinstitutionalization process for the Indiana State Mental Hospitals.
DEinstitutionalization of Indiana State Mental Hospitals; A Staff Report

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Model for Deinstitutionalization
(R. C. Scheerenberger)
In striving to improve the level of psychological and social functioning in our society and the quality of services available to the afflicted, we must remember that the many problems we face, of which mental health is only one, must be attacked not only through medical and educational endeavors but also within the content of an improving society, which strives toward greater social justice and a true sense of compassion for the weak and sick.

David Mechanic, Mental Health and Social Policy

It may be, however, that this society cannot mount a cooperative effort to change its social institutions. Issues of power and control may so preoccupy its decision-making members that improving the social position of its marginal members will be given a low priority. If such is the case, no research, however valid, can change those aspects of the society that are inhumane and unjust.

George W. Fairweather and Others, Community Life for the Mentally Ill

Preface

Publications such as Mental Disorders In Urban Areas by Faris and Dunham, Social Class and Mental Illness by Hollingshead and Redlich plus others provide insight into the causation of mental illness, especially in urban areas. While the estimated number of mentally ill people would vary according to the definition of mental illness and the survey process, many people do seek psychiatric services. In the recent past, these people were served in state hospitals usually located away from their community. (Some people did receive treatment by private professionals.)

Today, community psychiatric resources are expanding and there has been a dramatic decline in state hospital population. The return of the ex-patient to the urban area and the development of community services has changed how the mentally ill are served in urban areas. Thus, while the above and similar books help one to understand the relationship between urbanization and mental illness, the public administration task of providing needed services under rapidly changing conditions remains.
Introduction

A recent social problem has been the reduction in the population of state mental hospitals. The return of ex-patients to urban communities and placement in nursing homes have been discussed in the popular press and professional literature.\(^1\) There has been a reduction in the population of the Indiana State Mental Hospitals and a forecast that this trend will continue.\(^2\) There is a need for social planning to insure that ex-patients who are returned to Indiana's urban areas receive their needed care, training, and therapy in a dignified and humanitarian manner.

Objective of Study

The objective of this study is to review the social science and related literature and develop social planning recommendations for the deinstitutionalization of the Indiana State Mental Hospitals.

Brown\(^3\) has developed an operational definition of deinstitutionalization with three essential components as the following:

1. The prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment;

2. The release to the community of all institutional patients who have been given adequate preparation for such a change;

3. The establishment and maintenance of community support systems for noninstitutionalized persons receiving mental health services in the community.

The following is a short description of the Indiana State Mental Hospitals.

There are six state hospitals that serve primarily the mentally
ill for all of Indiana. Each of these state hospitals has a geographical district composed of counties. The hospital district is compatible with the boundaries of catchment areas for community mental health centers. Each of the planned thirty-two mental health centers is assigned to a single state hospital. The alcoholic and drug abuser is served in the mental illness state hospitals.

The six district Indiana State Mental Hospitals include Dr. Norman Beatty Memorial Hospital at Westville (LaPorte County), Logansport State Hospital at Logansport (Cass County), Central State Hospital at Indianapolis (Marion County), Richmond State Hospital at Richmond (Wayne County), Madison State Hospital at Madison (Jefferson County), and Evansville State Hospital at Evansville (Vanderburg County). Beatty State Hospital has a specialized maximum security unit that serves the whole state.

There are two specialized state hospitals serving primarily the mentally ill (Evansville Psychiatric Children's Center at Evansville, plus LaRue D. Carter Memorial Hospital at Indianapolis).

Fort Wayne State Hospital and Training Center at Fort Wayne (Allen County), New Castle State Hospital at New Castle (Henry County), and Muscatatuck State Hospital and Training Center at Butlerville (Jennings County) are the three zonal state hospitals for all of Indiana. These zones are compatible with the three Health Systems Areas. Northern Indiana State Hospital and Training Center for Developmental Disabilities at South Bend serves as a specialized state hospital. Each of these four state hospitals serves the mentally retarded and other developmentally disabled. Developmental disabilities includes cerebral palsy, epilepsy, and similar handicapping conditions.
Review of the Literature

Functions of State Mental Hospitals

Clausen\(^4\) provides the following functions of a mental hospital.

The mental hospital may be characterized as a social establishment designed for the custody or care of persons who have exhibited a degree of mental disturbance which makes it difficult, dangerous, or inconvenient to incorporate them into normal family and community living arrangements. The public mental hospital is a legal repository for such persons, on the one hand, and a medical institution for treatment and care of patients, on the other.

Szasz\(^5\) suggests that state hospitals have an economic or income redistribution function.

As a result, major cutbacks in the expenditures of the mental health bureaucracy threaten the same kind of economic dislocation as do cutbacks in the expenditures of the defense establishment are, perhaps, equally "unthinkable."

Thus, mental hospitals have social control, custodial care, treatment, and income redistribution functions in our society.

Growth and Decline of State Hospital Population

The development of the state mental hospital in the United States in the late 19th century was a reform movement to improve the status of the mentally ill who were inadequately served in community jails, attics, and other living arrangements. Bart\(^6\) suggests that the moral treatment approach of the early state hospitals was abandoned for the "warehousing" in asylums usually located in rural areas with the influx of immigrants to state hospitals. The decline of Social Darwinism led to changes in treatment of mental patients with the current emphasis on treatment in the community.

The number of patients in state mental hospitals rose to 558,922 in 1955 and dropped to 193,436 by 1975.\(^7\) A variety of factors including the development of community based services, changes in admission
policies of state hospitals, plus others are discussed as the reasons for this decline.  

Hisle shows that the population in Indiana State Mental Hospitals rose to 15,583 in 1955 and declined to 6,637 by 1976.

Mental Illness as Deviant Behavior

A brief discussion of mental illness as a type of deviance should be introduced at this point to show how complex it is to determine the need for state hospital and community services. Angrist suggests that there are at least four positions or approaches on the nature of mental illness.

The first approach asserts that mental illness is a type of deviant behavior. A second position takes the basic premise that mental disorders are pathology or disease in the psychology or psychiatric sense and not pertinent to conformity-deviance theory, which is concerned with interactions in a social system. A third approach looks on some types of mental disorders as deviant behavior while other behavioral constellations are defined as illness or medical phenomena. Still a fourth standpoint calls for specifications of the definers of behavior according to their social status and degree of professional training.

The labeling theory in sociological literature stresses that deviant behavior is in part a product of social definitions imposed on a person by society. The psychiatrist and sociologist interpret behavior differently.

For example, whereas a psychiatrist would be prone to say (or imply) that a certain individual acts the way he does "because he is psychotic" sociologists tend to reverse the syntax - the individual is psychotic because he acts the way he does. The difference is not merely a choice of words; it reflects a basic contrast in perspective.

The psychiatrist Szasz and sociologist Scheff support the labeling theory of mental illness while Gove, a sociologist, feels that people hospitalized do have serious psychiatric disorders and
this theory is incorrect.

Mental Health Planning

The different approaches to define mental illness as described above plus the difficulty and expense to determine a "true count" by using available survey methods makes accurate incidence and prevalence data difficult to obtain. However, Solomen and Palch\textsuperscript{15} have an approach that seems to be a practical remedy to this problem.

For example, the case is made that treated patients comprise only a fraction of such patients; however, in a given locality, the factors that influence the value of that fraction probably do not change greatly over a short time, and data concerning treated patients do bear some relation to "true incidence" and "true prevalence." These data thus probably represent not only the best estimate of incidence and prevalence available but also useful estimates of these parameters . . . Indeed, the nature of the field is such no matter how much investigative effort is devoted to it, the conclusions arrived at will probably always have an irreducible amount of uncertainty. The wise approach would seem to be refine techniques as much as possible (as feasibly and as flexibly as can be done) and plan programs on the basis of the data, humbly realizing not only that the plans will be imperfect, but that where the imperfections lie cannot always be known.

Thus, while it is complex to determine the needed state hospital and community services, this planning task can be done within limits.

The accumulated knowledge found the social sciences, psychiatry, and public administration should be used to help forecast, plan, implement, and evaluate needed services to the mentally ill, the mentally retarded, and developmentally disabled, plus the alcoholic and drug abuser. The value of knowledge is in the betterment of mankind.

According to Waitzkin, social planners believe . . . "that accurate data about social problems will contribute to social change, ordered according to a rational plan. This belief is based on the assumptions that a comprehensive plan, once developed, will be carried out actually."\textsuperscript{16}

Experienced social planners know that the pure rational model to
planning needs to be tempered with the "art" of planning in using political processes. When there are alternatives plus values involved, the political process should make the final decision based upon the best possible data and knowledge of the consequences of each choice. Planning should be with the people affected by the implementation of such plans.

Mental health planning fits the following description by Moore.17

Uncertainty and lack of precise predictability arise from the complexity of dynamic patterns - that is, from a rather large "error" factor owing to the number and interplay of uncontrolled variables.

The mental hospital, as a social organization, will next be discussed.

The Mental Hospital as a Social Organization

Parsons18 provides a definition of a social organization.

It seems appropriate to define an organization as a social system which is organized for the attainment of a particular type of a goal; the attainment of that goal is at the same time the performance of a type of function on behalf of a more inclusive system, the society.

Johnson19 also has a definition of organizations.

Organizations are (1) goal-oriented, people with a purpose; (2) psychosocial systems, people working with groups; (3) technical systems, people using knowledge and techniques; and (4) an integration of structured activities, people coordinating their efforts.

What happens to a social organization whose function is no longer needed by society? When the Salk vaccine was discovered, the National Foundation for Infantile Paralysis changed its goals to fight birth defects as reported in Sills.20 When threatened by the loss of purpose, a goal displacement process may occur in which "official" goals are replaced by survival techniques.

However, one could view a state hospital as one sub-system of a
larger social organization, the Indiana Department of Mental Health. A change in function of the state hospital will alter other sub-systems, the community agencies. The changing functions of sub-systems within a social organization creates problems of goal integration. A total system point of view provides a basis for integrating goals of sub-systems into a systematic whole.\(^\text{21}\)

While one can observe the deinstitutionalization process from a systems viewpoint, an individual person is the patient or client involved. This individual human being must often navigate through complex social systems. Scott\(^\text{22}\) speaks to this point.

Clients who are expected to be prime beneficiaries of the activities of service organizations are often in a relatively weak position and therefore have difficulty in protecting their interests. The inability of clients to evaluate the services preferred them by the technically skilled organization members is one source of their weakness, and their problems are compounded in those cases where their participation is involuntary, as it is, for example, in public schools and, to a lesser degree, in public welfare agencies.

The following is a discussion of the review of the literature.

**Discussion**

The deinstitutionalization of state hospitals needs to consider the functions that such hospitals play in our society. The social control function has been lessened by recent court decisions and the increased usage of voluntary admissions. Judges can admit patients to community mental health centers as well as state hospitals.

The custodial function is beginning to be developed in the community by the development of halfway houses and alternate residential care services for the mentally retarded and developmentally disabled. The Department is assuming an increasing public housing function as
custodial care shifts to the community. This new function should be recognized. There needs to be increased coordination with land use planners over zoning and other requirements of developing these community residential services. The possible increased use of nursing home facilities require the joint planning with Health System Agencies. The placement of patients into community settings plus not admitting people who used to be sent to a state hospital for social reasons means a close working relationship must be developed with social agencies as well as private practice professionals. Standards need to be monitored to insure that proper care is given.

The treatment function will be increasing assumed by the community mental health centers. However, these facilities will need to increase their capability to treat many of those patients who in past times were sent to state hospitals.

The income redistribution function may be more difficult to move to the community setting. Many of the state hospitals are in rural settings and the local economy depends upon the state hospital as an industry. The deinstitutionalization process spreads the money to more communities but those areas where a state hospital is reduced may suffer. This is a complex problem that should be recognized.

As discussed above with the social control function, the change in state laws and court decisions has influenced the development of community services. While such laws could be changed and court cases decided that would slow or reverse the deinstitutionalization process, it appears that the trend is in the other direction.
"Label Jars Not People" was a headline in a recent publication of an agency serving the mentally retarded. While academic people can argue about the merits of labeling theory, there does seem to be a trend toward increasing tolerance and understanding of people who might appear to be "different." However, values in our society have changed in the past and as we go into the future, Social Darwinism thinking may become more pronounced.

Careful mental health planning is needed to insure that this reform movement back to the community will be handled in the best interest of the patient. The Department's "business" is service and this service can best be provided by a mix of state hospital and community settings.

The state hospital is a social organization. The deinstitutionalization process will change this social organization and dynamic change is needed for this social entity to survive. This change must be well planned with staged implementation to insure that patients (as well as staff) do not get forgotten.

**Social Planning Recommendations**

1. There should be increased capability within the Department to provide consultation to communities who want to develop halfway houses, small group homes, and other community residential services for the "public housing" or custodial function. This expertise is not now available. The knowledge of zoning requirements, housing values, mortgage payments, and other topics needs to be available to communities. There is also the need for coordination of health, safety, and fire inspections between other state plus local authorities.

2. The Division of Professional Services within the Department (this Division contains professionals that provide consultation to
the state hospitals and community agencies should make inspections to a sample of the alternate living arrangements to observe the level of care, training and treatment and how such services are provided. These placements are monitored but a special survey should be performed to insure quality of care. These inspections should be coordinated with other Divisions (especially the Division on Mental Illness, Mental Retardation, and Other Developmental Disabilities, plus Addictions), other state agencies (especially the State Board of Health when nursing homes are reviewed), local direct service agencies plus advocacy groups.

3. A special study on the economic impact of deinstitutionalization should be contracted. A study on the potential fiscal impact of closing a state hospital has been conducted. However, this recommended study should show how State and Federal mental health funds are being spent through the state as well as at the locations of the twelve state hospitals.

4. Utilization review committees should be organized between state hospitals and community agencies that would screen admissions and assist in discharge planning.

5. There should be the continued development of community mental health centers, mental retardation centers, halfway houses, small group homes, and other services according to the current State Mental Health Plan. The continued development of community alternatives should help avoid inappropriate admissions plus assist in placement of ex-patients back to the community.

6. Additional attention needs to be given to the delivery of mental health and other support services to the elderly. Mental health centers and clinics should make extra efforts to seek out the elderly who need psychiatric services but who are unable or perhaps unwilling to come to
to the direct service providers. Coordination is needed with social planning for the aged, which would include such programs as homemaker service, meals on wheels, recreation, day care, plus others. Since many elderly are in nursing homes, mental health services should be provided to these patients also.

7. The following are some topics within the deinstitutionalization process that should be further researched.

a. A study should be conducted on the effectiveness, efficiency, and productivity of the state hospital and community agencies. The study by Smith and King, Mental Hospitals, materials from the National Commission on Productivity and Work Quality, plus other sources could be used. Attention should be given to patient discharge rate and staff ratio.

b. A cohort study of admissions from a representative month should be conducted. Such a study would examine the length of stay by hospital by demographic and diagnostic characteristics.

c. A study should be conducted on the type of patient who is now in the hospital by diagnosis. Are we treating "sicker" patients than in prior years?

Summary

There has been a dramatic reduction in state hospital population here in Indiana and the United States. This deinstitutionalization process of returning ex-patients to urban communities plus screening of inappropriate admissions to state hospitals needs to be carefully planned to insure that proper care and treatment is provided. The literature on deinstitutionalization was reviewed and discussed plus social planning recommendations were developed. Topics for further research were presented.
Footnotes


3Bertram S. Brown, "Deinstitutionalization and Community Support Systems," Statement by the Director, National Institute of Mental Health, Nov. 4, 1975. (Mimeo.)


7Messa G. Meyer, "Provisional Patient Movement and Administrative Data State and County Mental Hospital Inpatient Psychiatric Services July 1, 1974 - June 30, 1975," Statistical Note 132, Division of Biometry and Epidemiology, National Institute of Mental Health, July, 1976.

8Ibid., pages 1 and 2.

9Marie E. Hisle, "Patients Present, Indiana State Mental Hospitals, End of Fiscal Year," Indiana Department of Mental Health, 1976.


12Szasz, op. cit.


BIBLIOGRAPHY


APPENDIX

The purpose of the appendix is to describe the statistical change in state hospital populations between 1967 and 1976 and discuss possible future changes in the number and type of patients that may be served.

Graph Number One shows the number of patients present in all Indiana State Mental Hospitals from June 30, 1876, to June 30, 1976, a hundred year period. Patient present is defined as those patients in the hospital plus those on visit or authorized leaves of seven days or less. Patients enrolled includes the patients present and all patients on leaves more than seven days. This graph shows a steady growth of people in the state hospitals with a peak in the fifties and a sharp decline in the late sixties and middle seventies.

What type of people were served in the six district state hospitals during the period of rapid decline? Chart Number One shows the patients enrolled by age by selected hospitals on June 30, 1967, as compared to June 30, 1976. There was a decrease in each age category in each of the selected hospitals except for the increase in the 25-34 age classification for Logansport, under 15 and 15-24 for Madison, and 15-24 for Richmond.

Chart Number Two shows the percentage of patients enrolled by age for these selected State Hospitals. There has been a general decrease in the older age classifications and an increase in young adults. However, it appears that on June 30, 1976, the hospitals have a similar mix of patients by age as they did on June 30, 1967.

Chart Number Three shows the admissions by age for the six selected state hospitals between FY67 and FY76. Central and Richmond had less admissions in FY67 than FY76. The other hospitals had more admissions in
FY67 than FY76. There was an increase in admission in the 15-24 and
25-34 age classifications for Central and Richmond. There was an
increase in admissions in the 15-24 grouping at Madison.

Chart Number Four shows the percentage of admissions and reflects
the general decrease in admissions of all age categories except for the
young adult population.
"HISLE REPORT"

Number of Patients Present, Enrolled, Admitted, and Discharged from State Mental Hospitals from June 30, 1876 to June 30, 1976.

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June, 1977
Deinstitutionalization and the Law

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ABSTRACT. Deinstitutionalization, while worthy of implementation in the case of many institutionalized retarded persons, may be fraught with personal and legal problems for others. These problems do not draw into question the overall value of deinstitutionalization or goals and strategies relating to it. They do require a careful examination of the benefit of deinstitutionalization for each affected person and of the process by which a decision is reached to carry out a particular community placement. Legal arguments may be advanced to require such an examination and to support an individual's claim to an institutional placement rather than a community one.

A new and major goal in the field of mental retardation is deinstitutionalization. This term refers to the return of persons residing in centers for the mentally retarded to community or home environments.

A compelling impetus in the deinstitutionalization movement is the assertion of legal rights on behalf of institutionalized retarded individuals. While the movement and this impetus are commendable and worthy of society's best efforts, there are unresolved implications in the deinstitutionalization process. Some of these are raised, not as objections to deinstitutionalization, which the authors support where in the best interests of the retarded person; rather, they are discussed as considerations directly affecting the individual, not the value of deinstitutionalization or general goals and strategies related to it.

It is anomalous to speak of the law and deinstitutionalization without at the same time speaking about the law and institutionalization, for what is at stake either is a decision as to the person's appropriate life style, a decision as to what is the "best" placement of that person, whether in an institution or within the community in some smaller institution. Accordingly, many of the legal issues that will be discussed have relevance to both deinstitutionalization and institutionalization.

Two words of caution are in order: first, there are innumerable legal issues in deinstitutionalization, not all of which are discussed here; and, second, some of the legal issues that are discussed are more in the realm of projecting what the state of the law should be or might become than they are settled legal principles. The discussion of these issues is deliberately selective, speculative, and argumentative.

Due Process

As a general rule, a "voluntary" admission of a mentally retarded person can be lawfully made by the parents or guardian of the mentally retarded person, subject only to the approval or withholding of approval by the institution's administrators. At the same time, the decision to deinstitutionalize the person frequently is also lawfully made by only the administrators of the deinstitutionalizing facility, the person's parents or guardian, and the administrators of the community facility to which the person is being transferred. At no time in these decisions does the retarded person have a right, or even an opportunity, to make a decision for himself, to affect a decision being made for him by others, or to even participate in the decision-making process—when the decision vitally affects his lifestyle, his "best" placement, where he will be, and who will take care of him in what situations and surroundings.

Recently in an institution for the mentally retarded, a 30-year-old resident, who is severely physically handicapped, commented, "I am not trying to brag but I am not mentally retarded. Do you think I should be in this institution?" Upon investigation, it was discovered that he has an IQ of 77 and, arguably, he should not be in an institution for the retarded. Although the placement decision was made on his behalf and seemingly in his best interests by his parents, he was excluded from the decision-making as to his most suitable living arrangement. This particular individual has written letters to legislators and state agency officials and informed them that he has been inappropriately institutionalized. He does not understand the legal details related to due process; however, he understands the basic premise that he should have a right to participate in the decision concerning his lifestyle.

Considerations of extending due process to retarded residents in regard to discharge can also work in the other direction. When a young adult residing in a nearby residential institution was approached as to the possibility of leaving the institution and living in a community group home, the retarded individual was outraged and insulted. He was very happy with his institutional lifestyle and wanted to remain in the institution. The decision was made by professionals that a community placement would be more normalizing; however, he did not want to live in a community environment. Does this individual have the right to choose the institution as his most appropriate placement?
The law has denied a right of opportunity to participate because it traditionally thought of the retarded person as being unable to participate in those decisions, and because it has assumed that the person's parents and the administrators of the institution in which he is placed will act in his best interests. Yet the best interests of the retarded person are not always the same as, and indeed frequently conflict with, the best interests of the parents or the administrators.

If there is a conflict of interests, then it is inappropriate for the law to sanction any process which excludes the mentally retarded person or his independent advocate from the decision-making process. When a person is on trial for a criminal offense and pleads temporary insanity at the time of the offense or the inability to stand trial for the offense because of mental incapacity at the time of the trial, he is not required to do so through his own effort but is entitled to a lawyer to assist him. It may seem a bit far-fetched to argue the criminal analogy with respect to the placement of a retarded person, but the considerations are the same.

A decision is made to place a person in one case, in a prison or in an institution for the mentally ill; in another case, in a mental retardation facility; the person is not capable—or is not fully capable—of meaningfully participating in and arguing his interests during the decision-making process; and the public's interests are represented (at the criminal trial by the prosecuting officials and in the placement process by the parents and by the administrators of the facilities). The crucial difference is that, in the criminal proceeding the mentally ill person has a right to have somebody appointed by the court or selected by him to argue his interests; whereas in the placement of a mentally retarded person, the retarded person has no right to have a person appointed by anyone or selected by him to argue his interests. The decision to place the mentally retarded person in an institution or a community-based facility is analogous to, and the same considerations in those placements are involved in, placement in the parental home, a foster home, a group home, or with friends of the retarded person or his family.

There are some other procedural matters in which the law is inadequate. What process is followed in a decision to institutionalize or deinstitutionalize? Is it a quasi-judicial process in which the various and conflicting interests and claims can be advanced and impartially resolved? Who has a right to be or in fact is involved in that process? Is a judgment made on the basis of all of the facts involving not only the retarded person but also his family, the institutions, and their suitability for him? Are the facts presented to and reviewed by an independent, objective person? Must his decision be made solely on the basis of the facts presented to him? Who presents the facts to him?

What are the operative facts? Finally, does an appeal lie from that person’s decision? If so, to whom—an impartial review agency? Almost without exception, the answers to these questions are negative.

In all but one instance where the public, through government, takes action with respect to the liberty or property of an individual, the law has insisted upon “due process”—a right to confront the public or its representatives and be heard by an impartial arbiter before the public takes action with respect to the individual. The glaring exception has been the decision to place a person in an institution for the mentally retarded or to deinstitutionalize him. The state of the law now is that, as a general rule, due process is granted only with respect to the placement of a retarded person in special education programs, but not in the far more confining, liberty-depriving placement in institutional or community-based facilities or in parental or surrogate parental homes.

The numerous persons involved in a placement decision—parents, social workers, institutional administrators, psychologists, physicians, teachers, and sometimes judges—have enjoyed substantial immunity in the placement process with the exception of the judges, whose decisions are at least usually appealable to higher courts. Their decisions, both individually and collectively, have frequently been accepted by the persons affected; more often, their decisions have been implemented without the person affected being involved or having a chance to approve the decision, participate in it, or object to it. This immunity, however, may soon become obsolete, for litigation is underway challenging the placement decisions, with parents and legal advocates for retarded persons suing the decision-making professionals on the grounds that due process has not been adhered to in making the decision.

Professional Liability

A second kind of litigation challenging the professionals' immunity from legal procedures and culpability from the effects of their decisions will be forthcoming—the law suit by the affected person or by his legal representatives (parents, guardians, or next of kin) based on the torts committed by the professionals—malpractice, negligence, or tortious interference with the person. Consider, for example, the case of a trainable mongoloid child who, for each of the 12 years of her life, has been in an institution and knows no life except an institutional one. The decision to place the child in the institution was made by her parents on the advice of a pediatrician who admits to having no training with respect to mental retardation and who made the decision based on his general knowledge of retardation and particularly of mongolism—"these children simply can't learn anything.
they can’t be trained, they will die soon, and they ought to be out of the home.” A decision such as this undoubtedly is grounds for a lawsuit for professional malpractice. Malpractice litigation now bedevils the physicians. If similar advice had been given by a psychologist instead of a physician, it most likely would not have been actionable by malpractice litigation. But surely the standards of professionalism that the law applies to one profession should be appropriately applied to others, especially where the medical professionals frequently jointly participate with other mental retardation professionals in placement decisions. It is safe to predict that malpractice litigation will soon be brought against the social workers, institutional administrators, psychologists and educators whose professional advice is sought and followed in placement decisions. If they give unprofessional advice, they should be held accountable for their failure to give professional advice measuring up to and consistent with standards of professionalism in their respective professions.

The following passage is quoted from a report of a psychological evaluation conducted by a licensed clinical psychologist: “This young girl with an IQ of 52 will never be able to do so much as write her own name or cross the street by herself. Institutionalization should be carefully considered before the parents become further emotionally involved.” This psychologist did not realize the capabilities of a person with a 52 IQ. Luckily, the parents of this child failed to take this advice, and the child is presently achieving at the third level in a public school special education class. Where would the child be now if the advice of the psychologist had been followed? Would there have been grounds for malpractice?

Exactly what constitutes professional malpractice by a psychologist, an administrator or a teacher may be hard to define, but the glaring cases of malpractice are not difficult to identify, and they will initially set the standards for professional competency for money damages. An additional remedy must be granted. It should consist of a review of the decision that was grounds for malpractice and an effort to correct the wrong decision, remedy the improper placement, and secure appropriate placement. If the law will hold the decision makers accountable for their placement decisions, then no longer will it be possible for an administrator who seeks to reduce the population of his institution to single out a retarded resident and require that person to leave the institution without first making a decision, professionally supportable and based on all of the relevant evidence, not necessarily in the best interests of the administrator, the institution, the parents or other affected persons.

The Duty of Preparation
A third emerging legal problem is to define the role an institution plays in preparing parents, a resident, the receiving facility and the community in general for deinstitutionalization. It should not be legally sufficient that a decision to deinstitutionalize is made if the decision is not able to be properly administered in the best interests of the retarded person.

The parents of a 12-year-old mongoloid child who was institutionalized at birth have rarely visited their child in the last 12 years, their teen-age children do not know they have a retarded younger sister, and the family is totally unprepared emotionally and physically to have the 12-year-old retarded child at home. The child has learned the relevant skills essential for home and community living, and the institution is ready to discharge the child. Does it have the right to discharge a child to a family who clearly cannot handle the situation? What are the institution’s duties in family preparation? If a child returns to his family and the family later discovers that it cannot effectively cope with home placement, what recourse does the family have?

The duty of preparation also applies to training the retarded person. What happens to the retarded adult who is discharged to the community with no prior training in sex education? If he commits a sex offense without being provided adequate sexuality training by the institution, should not the institution be held legally accountable? As an example of the need to prepare the community, consider the 18-year-old who, having returned to the community, bought several bottles of beer at a local tavern and was arrested for intoxication. The officer testified that he looked funny and slurred his words and was walking awkwardly. The court, upon this evidence alone and without benefit of a breathalyzer or blood test, convicted him. But the young man always looked funny (he was mongoloid), he always slurred his words (he had a speech impediment), and he always walked awkwardly (he had gross motor difficulty). He was not drunk, simply retarded.

Counseling the parents, making preparations in the community, working with the receiving facility, and training the retarded person himself for community placement, are not yet recognized as legal responsibilities of a deinstitutionalizing facility. Nor will these become legal responsibilities until legislative or administrative regulations are adopted requiring preparation for deinstitutionalization or until the courts hold that the professional at the deinstitutionalizing facility are professionally responsible to carry out those duties and may be held accountable in a malpractice action for their failure to perform them or may be restrained from deinstitutionalizing a person if they have not complied with the duty of preparation.
The Obligation of Equivalency

A related concern deals with the availability or unavailability of services in the community. Again it should not be legally sufficient that a retarded person is discharged to the community if there is not available in the community the same kind and quality of services available to him at the discharging institution.

Many people assume that any community is well suited to provide a continuum of services to the retarded person and that the community is unequivocally the most appropriate placement. What about the community that provides no educational programs to moderately, severely, and profoundly retarded individuals? In some cases of deinstitutionalization, the retarded person has left an educational program or a sheltered workshop in the institution and has been discharged to a community environment in which programs are unavailable. Has his lifestyle improved or has he lost opportunities for development?

Services at institutions and in the community are not what they should or can be but community services should at least be the quantitative and qualitative equivalents of services at the discharging institution. If they are not, the retarded person falsely has been adversely affected by a governmental decision by being denied the same quantitative and qualitative services in the community as he had in the institution, and therefore has been injured and has a right to be recompensed for his injury. Some court decisions in right-to-treatment litigation hold that a person who is institutionalized on account of his retardation has a constitutional right-to-treatment as a person *quid pro quo* of his being institutionalized. It requires only a small extension of this right to hold that a person discharged into the community retains the right although he is no longer institutionalized as long as he can demonstrate a need for treatment. It would be not only unfortunate but also constitutionally doubtful if the state could avoid its duty of treatment by deinstitutionalizing a person.

If this extension of the right-to-treatment can be made, the effect will be to insure that an administrative discharge of an individual can be judicially reviewed. Even if procedural due process standards are complied with, the right-to-treatment argument will allow a retarded person to argue and prove that he still has a need for treatment. If the community into which he is discharged has community- or home-based facilities, then perhaps his need for treatment can be met in that form.

The tough case, however, occurs when the two choices are total maximum institutionalization or complete discharge from treatment and control. In that situation the retarded person, if he can prove, he is harmed (deprived of treatment) by the discharge, should be allowed to return to or remain in the institution.

If this sort of lawsuit is allowed, administrators of mental retardation facilities might defend their actions as being consistent with the "least restriction alternative" rationale. This argument was first used by commentators who have recently been writing persuasively that a person whose liberty is infringed upon by the state should have the right to the least restrictive form of commitment; in the case of mental retardation, they argue for the least restrictive form of treatment. The idea has been successfully argued in some mental retardation litigation, and the basic argument is often used by administrators to discharge patients from the facility. The argument is probably legitimate when there are adequate alternative (i.e., community) treatment facilities available to a retarded person. But when there are no alternative facilities, the least-restrictive-form-of-treatment justification for dismissal is clearly invalid, and should be no defense to a right-to-treatment suit brought with the purpose of preventing deinstitutionalization or returning a patient to an institution. The only time it should be a defense is when there are community facilities available and the resident can benefit at least as much, if not more, from the community facilities than from the institution.

If a person is going to be injured or damaged by the community placement, he should be entitled to money damages, but if money damages will not compensate him adequately, he should be entitled to a court order that he not be deinstitutionalized until quantitatively and qualitatively equivalent services are available in his new placement setting.

The Transfer of Rights

It is not clear that the rights possessed by a resident of an institution survive his deinstitutionalization and carry over to the community. In North Carolina, for example, legislation affords residents of mental retardation centers certain rights, but no legislation provides that they shall have the same rights when they are deinstitutionalized to a group home, a foster home, their parents, or some community facility. Do they still have the right to privacy and to ownership or personal belongings? Should they have an individual evaluation and habilitation plan as was required when they resided in the institution? Who in the community is to be held responsible for informing the person of his rights and advocating on his behalf? The same legal recourse arguable available to a person deprived of equivalent services upon his deinstitutionalization should be available if in-institution statutory rights are lost upon deinstitutionalization.
The Duty of State Subsidy

A legitimate public and private concern is the cost of deinstitutionalization. How do the costs for community-based care compare with the costs of institutional care? ("Costs" include not only fiscal costs, which may be originally higher for community care than for institutional care but which over the long term may be lower, but also "costs" saved in terms of human gains.) If they are less, and if the retarded person is being returned to his parental home or even to some nonpublic home such as a foster home or group home operated by an association of retarded citizens, the state is saved the greater costs of institutionalization, but the cost is transferred from the public sector to the private sector. Should not the government—the public sector—provide some recompense or subsidy of the costs of retaining the retarded person in the community at a private facility? What about the case of a deinstitutionalized child who goes back to a community where he is excluded from public school programs or possibly too young for public school? One recourse of his working parents is to place him in a private day care center at approximately $150 to $200 per month. While he was previously living in the institution, the state subsidized the cost of his training program; however, upon discharge to the community, his parents were required to assume the financial burden from the state. One father of a severely retarded boy living at home commented that he is often tempted to teach his son to commit a criminal act. If the boy were a criminal, he could receive rehabilitation at state expense. However, since he is not a criminal and he is retarded, the boy is excluded from many public programs and the family must purchase private care. There is no clear duty now of public recompense (and the duty will come only from legislative action), but the savings to the public sector are obvious if deinstitutionalization is made to a private facility and the state should not so easily escape the costs of its responsibility of care for the retarded person. Recompense could take the form of direct transfers of money, living cost subsidies, social security benefits, and tax credits, among others.

The Duty to Monitor

A major problem is that of monitoring the quality of the care in the community. For purposes of argument, assume that the quality of care in the institutions is monitored and that standards are set and met to adequately safeguard the retarded person while he is in an institution. (To assume this is to ignore the evidence that there is insufficient monitoring or no monitoring at all and that the standards of care are far below what is legally tolerable.) The law has not yet begun to address issues of monitoring the care and setting standards for the care of retarded persons in the community, except insofar as it requires compliance by community facilities with building codes, fire codes, and related standards for the physical facilities in which the retarded will be living. The law is just now beginning to define and provide for the types of community services that make deinstitutionalization possible. The law has yet to address whether the now emerging standards for care and treatment in the institutions will be applied to deinstitutionalized persons, and, if so, whether they will be applied to both governmental and private facilities and professionals. What happens when the management and operation of group homes is detrimental to the welfare of the retarded individuals living in them? Who monitors the quality of service delivery? For example, consider the case of a retarded adult in a nursing home who is afforded no opportunities for self-development or self-expression. This does happen far too often, since few monitoring systems have been developed.

The retired person might successfully contend that he would be endangered or injured if he were deinstitutionalized to a facility or persons not required to live up to the standards set for his care in the institution. Accordingly, he might be entitled to money damages or an order restraining his deinstitutionalization.

The Right of Voluntary Discharge

Another issue concerns the right of a resident to leave an institution if he has been "voluntarily" admitted or has "voluntarily" admitted himself. If voluntary admissions are in fact not made by the retarded person himself but rather by various persons affected by that decision, and if the retarded person decides that he wants to leave the institution (voluntary discharge and deinstitutionalization), should he have that right? In North Carolina, legislation provides that a person voluntarily admitted to an institution for the mentally retarded may, upon several hours' notice given to the administrators in writing, receive an automatic discharge. While one's innate senses of civil liberties and rights might be warmed by this legislation, one's senses might also recollected at it if the administrative discharge of a "voluntary" admittee results in his return to the community in which he is not prepared to live or a return to a community that is not prepared to accept him.

At one of the regional centers in North Carolina a "voluntarily" admitted adult patient requested his discharge and received it within several hours after his request. He thumbed a ride down to a nearby interstate highway and then, while he was thumbing a ride along the interstate highway—knowing the rules of the road, was struck and killed by a car whose driver was driving lawfully.
but who could not avoid hitting the retarded person when he jumped in front of the car, apparently thinking that the car would be able to stop within the available distance. A review of the voluntary discharge legislation seems required if only because administrators of the institutions have failed to prepare their resident for community living. Should an administrator of a discharging institution be liable to the retarded person, or his estate, if the discharge results in injury that would not have come if the retarded had been properly prepared for discharge?

The Legal Assumption in Favor of Parental Custody

Another issue surrounds the legal presumption in favor of custody of a child by the parents—a presumption that rests on the assumption that the parents are the best persons to care for their child. The parents may have been the persons who initially institutionalized their child; they also may be financially, psychologically and physically not as well equipped to deal with and provide for the retarded child as a group home facility, a foster home, or adoptive parents. Should parents be encouraged to deinstitutionalize their child when it is obvious they do not have the coping skills to make successful adjustments? When a retarded child is returned to a highly unfavorable home environment where supportive services have failed to bring about change, should parental custody be denied?

When the assumptions in favor of parental custody are or might be in error, the legal presumption should not exist, and an independent determination into suitability of the parents should be made.

The Parental Veto

A related issue is the almost absolute right of parents to object to or veto the placement of their retarded child in a community facility other than their own home or in a foster or adoptive home. If the institution wishes to deinstitutionalize a retarded person and if the parents do not want to have the retarded person returned to them, the only alternative for deinstitutionalization is placement in the community with some persons other than the parents. This placement sometimes will be objected to by the parents for a variety of reasons: the unsuitability of the alternative placement; the implicit rebuttal by the alternative placement of the parents’ judgment that institutionalization was best for the child in the first place; the sense of guilt that parents feel when confronted with the possibility that other persons are capable of taking care of a retarded child in the community although the parents themselves were not, as evidenced by their placement of the child; and the parents’ sense that they are or will be socially stigmatized if they have a retarded child at home. A pending case at a nearby institution involves an 11-year-old child who has developed the necessary skills for home and community living; however, her parents refused to take her home and have vetoed alternatives such as a foster home or a group home placement. A father commented in a recent parent interview: “This institution is the ultimate place to be, and it gives me such mental comfort to know my daughter is here.” Should this child be required to spend the rest of her life in the institution because her parents have refused to have her at home and have denied permission for an alternative placement? Where do the parents’ rights end and the child’s rights begin?

The legal presumption in favor of parental placement needs to be reconsidered and the parents’ ability to object to or veto other deinstitutionalizing placement should be curtailed when deinstitutionalization is in the child’s best interests but not in their own.

The Duty of Truth in Placement

There has been very little “truth in placement” in institutionalizing or deinstitutionalizing a person. While federal and state legislation regulates truth in lending and the sale of consumer products, no legislation requires “truth in placement.” No legislation requires an institution or a community facility to disclose to the persons making the placement its financial strengths or weaknesses, its staff-to-residents ratio, the programs that will be made available or are not available, the types of diet provided, the fact of compliance or noncompliance with local building, zoning or fire codes or with accreditation standards, the professional qualifications or on-the-job experience of its staff, or other matters relating to the suitability of the facility and its staff for the retarded person. Thus, the parents of a retarded person or his guardians might have to place him in an institution without having the benefit of detailed information concerning the facility itself. If, as has happened, the facility has to close for various reasons, the entire agonizing, expensive and time-consuming process of replacement must be embarked upon.
again. A further refinement of “truth in placement” legislation would be legislation obligating a private facility to post a financial responsibility bond, or obligating a public facility to provide financial recourse, for parents or guardians who are put to any expense because of the closing of the facility. When such an important issue as placement is at stake, some form of disclosure should be required so that the placement decision can be founded upon all available facts, and some form of recompense in the form of a financial responsibility bond of assurance should be made if placement cannot be fulfilled.

Refining Guardianship

The entire law of guardianship needs to be explored and refined. Traditionally, a court appointed guardian is available to a person who is incompetent to manage his own affairs; accordingly, a guardian can be appointed for most retarded persons. Traditionally also, the guardian is wholly and entirely responsible for the management of the affairs of his ward; accordingly, the guardian of a retarded person has the absolute authority over the property and even sometimes over the person of his ward. This concept of total guardianship is inconsistent with the emerging models of retardation, which teach that retarded persons are capable of performing some functions and making some decisions for themselves. If a retarded person is capable of managing his property and money, and deciding the amount or type of social freedom he wants, the laws of guardianship should be revised to provide for a limited guardianship in which the guardian has only partial control over certain aspects of the property or person of his ward. If the emerging models of retardation correctly teach that there are degrees of retardation and capabilities among retarded persons, there should thus be degrees of guardianship, tailored to the particular individual and his capability, rather than a single type of guardianship, the complete guardianship, tailored to outdated and invalid assumptions.

Conclusions

Much of the law of mental retardation is just now being developed, and its implications are in the throes of being initially explored in light of our new understanding of retardation and our new sense that retarded persons are entitled not only to human rights but also to legal rights. The warehouse-type institution is not the least restrictive setting for the care, habilitation, training and development of retarded persons. In some institutions, the most shocking infringement of rights has been found. Living conditions are so deplorable that they raise questions of whether the Eighth Amendment, prohibiting cruel and unusual punishment, has been violated. Some types of “treatment” employed in them raise questions of unconstitutional intrusions into the life and liberty of the residents. Rights to education and treatment, although tenuous in the community, are most likely to be denied in institutions. And rights of the retarded person and his family are most likely to be surrendered under a theory of in loco parentis, a theory that holds to the belief, so widely contradicted by the evidence, that institutions will act as parents would in the best interest of the retarded residents. It is largely because of the failure of our institutions that we have adopted the belief that deinstitutionalization by less restrictive forms of placement is the constitutionally required placement.

And yet a word of caution is in order: deinstitutionalization, without necessary legal safeguards, will not be a satisfactory answer to the problems of institutionalization, but will merely be an unwitting way for replacing the infringements on legal and personal rights that retarded persons have suffered in institutions by similar infringements to be suffered elsewhere. In short, we must apply the fullest legal protections that the person in the institutions are now belatedly and partially receiving to the persons who are being deinstitutionalized.

References


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1D. A survey should be made of the employees of the Indiana Department of Mental Health to determine their staff development needs at this point in time (April, 1975). This information would provide baseline data for a staff development program to meet the needs of the mental health delivery system in 1980.

1E. There should be a continuous staff development program organized to meet the changing needs of the state hospitals. The staff development program should include such things as pre-service and inservice training programs, self-study, planned work experiences, visits to other state hospitals and community agencies (including out-of-state trips) horizontal transfers within the state hospital system and the Central Office, exchange employee program within state government, community agencies, participation in state and national professional organizations, attendance at state, regional, and national conferences, encouragement of applied research and the publication of the findings by an in-house publication or national periodicals, and other such adult learning experiences to enable the employee to be more valuable to the state hospital.

1F. The adult educator at the Central Office level and at the state hospital should recognize the Department of Mental Health as a social organization as well as a unit of state government. There is a very definite informal structure that exists with the formal table of organization. There is a large number of employees with many years of service who know each other. The adult educator will need to be able to work with the informal system, especially if the organization is threatened with lay-offs or closing of a hospital. The Central Office needs to recognize that, while he may have authority, he will need to
earn the power to implement his programs within a state hospital managed often by a medical doctor with considerable independence. Each hospital has its own social system and relationships to community agencies. The reference groups of many of the staff may be more concerned with in-hospital programs rather than hospital-community activities. However, the reference group of newer staff members may be oriented toward community programs without an understanding of the possible contributions of a state hospital. A staff development should address both situations.

As state hospitals become smaller there may occur a change in a state hospital. Some state hospitals have already moved from departmental to an unit system. More personnel will be working with community agencies and some departments, such as nursing, dietary, maintenance, and others will lose employees.

1G. As state hospitals become smaller they will become more multi-purpose and serve mentally ill, mentally retarded and developmentally disabled, plus the drug abuser and alcoholic. A staff development program will need to upgrade the clinical skills to serve patients who have traditionally not been served in a particular state hospital. State hospitals that have formerly served mainly the mentally ill will have additional mentally retarded patients. State hospitals that have specialized in serving them, mentally retarded may need to serve the mentally ill patient.

1H. More attention should be given to public education and information by the adult educator. The consumer of the services and the general public should have a better understanding of mental health (as opposed to mental illness) and should know what to expect if they seek professional services for an emotional problem.
Ramification

2. If the patient population continues downward as forecasted, then a General Assembly may decide to close one or more state hospitals before 1980.

Recommendation

2A. The Department should develop general plans to close a state hospital that includes the treatment needs of the patients and the employee rights. This would be a general plan that could be readily adapted to any of the state hospitals. This plan should include special provisions for a state hospital serving the mentally ill as well as a state hospital serving the mentally retarded and developmentally disabled.

2B. The Department should work very closely with unions, employee associations, and professional societies who represent the staff members at state hospitals to insure proper communications.

2C: The reduction of census or the closure of a state hospital may result in some older employees deciding to take an early retirement. The state hospital should provide pre-retirement planning as a part of the staff development program for these people.

Ramification

3. If the patient population continues downward as forecasted the administrative staff at the Central Office and the state hospitals may not have all the management skills to accomplish this task in the best manner possible.

Recommendation

3A. The Department should develop a management training program to upgrade the skills of administrative staff members in the Central
Office and state hospitals. Consideration should be given to contracting with the School of Public and Environmental Affairs at Indiana University for a specialized inservice training program. Resources at other universities should also be considered. Also, the Department should consider having new staff members with backgrounds in operations research, systems analysis and similar fields. Scholarships should be provided to current employees to upgrade their skills to meet this need. Such scholarships would provide a career ladder for current employees.

3B. While the Department of Mental Health may be providing less direct services through state hospitals, more responsibility will be given to our planning, implementing, monitoring, and evaluating enlarged community programs. The management training program should include skills necessary to properly manage an expanded community program. Program standards should be developed for patients placed in nursing homes, half-way houses, small group homes, apartments, and other community living situations. Standards, rules and regulations, plus licensing requirements for community mental health centers, private psychiatric hospitals, day care programs for the mentally retarded and developmentally disabled, alcoholism and drug abuse treatment programs, and community residential services should be further developed and enforced.

3C. There should be developed a contingency plan to provide vocational training to staff members who might be layed off if a hospital closed.

3D. The managerial training program should not only include those people who hold top administrative positions but middle management personnel who often have a fine background in a clinical discipline, but little background in administration.
3E. The following are some of the subjects that could be included in a management training program in addition to basic administrative skills: labor relations, use of data, supervisory training, use of the computer, administrative law, cost-benefit analysis, use of PPBS and other budgetary systems, program planning and evaluation, organization theory, operations research, dealing with regulatory agencies, and other such topics.

3F. Since most state hospitals and state aided community agencies have in-house closed circuit television, this media could be used in the staff development process.

Ramification

4. The reduction in the number of patients in the state hospital system plus the growth of community agencies will change the organization of the state hospitals and the Department as a whole.

Recommendation

4A. The state hospital system should become more "open" rather than relatively "closed" as in past years. More emphasis should be placed upon joint learning experiences between state hospital personnel and people in the legal system (lawyers, prosecutors, judges, police, correction officials, and others), medical system (family doctors, private psychiatrists, public health nurses and paraprofessional staff, hospital administrators, hospital trustees, pharmacists, and others), welfare system (caseworkers, supervisors, directors, welfare board members, welfare rights groups, private social agencies and others), plus the education system (teachers, guidance counselors, principals, directors of special education, superintendents, school board members, parent-teacher organizations, and others).
4B. There should be the continued interaction between the Department of Mental Health and other state agencies such as the State Board of Health, Department of Public Welfare, Department of Public Instruction, Department of Corrections, State Division of Planning and other units of state government.

4C. There should be more contact between the Department of Mental Health and private funders and third party payers of mental health programs, such as Lilly Endowment, Indianapolis Foundation, WHAS Crusade for Children, Indiana Blue Cross, private insurance companies, and other such organizations.

4D. Staff training in Organizational Development should be provided to both state hospital and community agency personnel to assist in the organizational changes that will occur.

4E. Policy decisions at the highest political level will be needed on the state hospital's organizational role to service long-term chronic patients, many who are aged, who do not need intensive psychiatric treatment and who are not dangerous to themselves or society.

4F. The Department of Mental Health should further develop the "Zonal Planning" between MR/DD agencies and state hospitals serving the MR/DD patients. Also, the "District Planning and Budgeting" model developed in the Madison State Hospital District between this state hospital and its community mental health centers should be expanded to the other district state hospitals serving the mentally ill. There should be close linkages with area comprehensive health planning agencies, regional land use planning agencies, criminal justice regional planning organizations, area councils for the aged and other such planning agencies that plan on a sub-state level.
Summary

Staff development recommendations were made from ramifications of a forecast of the mental health delivery system for Indiana state mental hospitals in 1980. It was forecasted that the patient census at the state hospital will continue to decline. Assumptions used in the forecast were presented. The 1980 mental health system would be composed of well developed community services with much of their funds being generated by national health insurance. There will be an increased need to further develop the management capability of the state hospitals and community agencies. Staff development in clinical areas will also be stressed. The adult educator at either the Central Office level or at the state hospital needs to remember the social organizational characteristics of the new evolving mental health delivery system.
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**Error Range**: 6,982–7,268
Deinstitutionalization: An Analytical Review and Sociological Perspective
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PREFACE

It is rare today to read a professional or lay article in the field of mental health that does not in some way depart from, allude to, and/or offer criticisms of or suggestions for implementing the deinstitutionalization of mental patients. Rarely defined in a precise manner, the very term deinstitutionalization evokes intense emotional and partisan responses. It is the verbal referent of a movement in mental health which has for over a decade preoccupied clinicians and researchers, citizens and politicians. The literature so abounds with articles concerning the various aspects of deinstitutionalization, that it would be very difficult indeed to present a systematic and coherent summary of all that has been written.

Originally, this work was intended as a summary review of the literature dealing with the issues in deinstitutionalization. As I began, however, to accumulate an ever-lengthening bibliography, it became clear to me that still another narrative review of issues could be of only marginal value; somehow, it seemed that it had all been said before. Gradually, but firmly, the recognition grew that both the deinstitutionalization movement and the literature that discusses it are plagued by a common problem: the absence of a clearly outlined theoretical framework. The more I began to understand the dimensions of this deficit, the more appropriate it seemed that the present study should in some way attempt to go beyond a mere enumeration-cum-discussion of the issues surrounding deinstitutionalization. It should, instead, have as its major purpose the attempt to tie together in a coherent and meaningful way those questions that have already been raised and those insights that have already been proffered, in the hope that such synthesis will lead to a kind of understanding that can be used by planners and program implementers of the future.

Accordingly, this work is to be regarded as an analytical review and theoretical synthesis of the issues in deinstitutionalization. It is not, per se, a comprehensive review of the literature. The bibliography is extensive, but it is not “complete.” Because it would be extremely difficult, and probably not very productive, to include all deinstitutionalization references in the bibliography, I have selected for inclusion those writings—both professional and lay—which support or illustrate points I wish to make in the analytical review.

My training as a sociologist has predisposed me to interpret the literature in certain ways, and I have utilized some of the insights of other sociologists to help me formulate my theoretical conception of the issues in deinstitutionalization. I should like to make it clear, however, that I do not feel that a sociological approach is, sui generis, the correct way to view the issues. I feel, rather, that the deinstitutionalization movement should be studied from a variety of perspectives. It is such a complex phenomenon, that there must be many levels of productive analysis, and a sociological approach is but one of several possible frameworks. The basic consideration at this point is to stop looking at deinstitutionalization as if it is made up of discrete problems begging for rhetorical commentary and to start looking at it in a new way. The new perspective must represent an effort to understand why the many problems are occurring, and it must attempt to explain the interrelationships among these problems.

In summary, this work is to be regarded very much as a first step in the systematic understanding of the deinstitutionalization movement and of the issues that have surrounded it. In serving as a basis for future investigation, it will doubtless raise more questions than it answers. Hopefully, however, these new questions—unlike the old—will be of a kind that can be translated into action.
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Series D. Conference or Committee Reports, and analytical reviews of literature: Conference and committee reports and analytical reviews of the literature on subjects of general interest to the field.
Deinstitutionalization:
An Analytical Review
and
Sociological Perspective

Leona L. Bachrach, Ph.D.
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I. INTRODUCTION

"There is a serious, one might even say schizophrenic, contradiction between two of the most important trends in present day community mental health. On the one hand there is a mass exodus of long-term psychiatric patients from the State Hospitals with the assumption that they will be cared for by community mental health programs. On the other hand, the trend in community mental health is toward programs which tend to exclude long-term patients, that is, intensive care programs with emphasis on crisis intervention."

—H. Richard Lamb, 1975

TOWARD A DEFINITION OF DEINSTITUTIONALIZATION

In a statement concerning deinstitutionalization, Bertram Brown (1975), the Director of the National Institute of Mental Health, has provided an operational definition of the term. He has described three essential components of deinstitutionalization: (1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment; (2) the release to the community of all institutional patients who have been given adequate preparation for such a change; and (3) the establishment and maintenance of community support systems for noninstitutionalized persons receiving mental health services in the community. Brown's statement is a description of an ideal. It expresses goals which, at this time, are still to be achieved. As a definition of what deinstitutionalization should or might be, it is an eloquent statement; as a definition of what deinstitutionalization is, it is still anticipatory.

In practice, the term deinstitutionalization is used in the literature to refer to a broad scope of patient-connected events, ranging from carefully planned local efforts to achieve the ideal expressed by Brown to the mass release of patients to communities as State hospitals have been "phased out" or closed. In some of the latter instances, patient release has been accompanied only by the most minimal pre-release patient preparation or planned community support. Almost always, in the literature, the term is used vaguely. Even some of the excellent treatises on the consequences of deinstitutionalization have failed to define it precisely. Sometimes the term appears to be used synonymously with "community mental health"—another movement which has paralleled the deinstitutionalization movement in time. Both have responded to the same social forces and are, in fact, philosophically very close relatives (Goldman 1976). However, the community mental health movement is broader in scope, for it concerns, in addition to the treatment of the noninstitutionalized mentally ill, the treatment of other individuals who would not be considered potential candidates for institutionalization (Dinitz and Beran 1971; Simon 1975). The community mental health movement is also concerned with providing a range of indirect services, aimed at the prevention of mental illness, which are not ordinarily considered to be within the scope of traditional activities conducted at mental hospitals (Wagenfeld 1972).

For purposes of the present study, deinstitutionalization may be understood as a process involving two elements: (1) the eschewal of traditional institutional settings—primarily State hospitals—for the care of the mentally ill, and (2) the concurrent expansion of community-based services for the treatment of these individuals. There are, actually,
two components of the deinstitutionalization process: the removal of persons who have already been hospitalized from their institutional environments and their transfer into the community; and the prevention of hospitalization of those persons who might be considered potential candidates for institutionalization.

Deinstitutionalization is, however, more than a process concerned with the locational aspects of patient care. It is also the expression of a philosophy rooted in an era of social and political reform which strongly emphasizes peoples' self-determination and their right to control the forces that affect them (Hersch 1972). It is important to understand this aspect of deinstitutionalization. Were only the locational aspects of patient care at issue, the movement might have caused only a minimum of controversy which could be relatively easily negotiated and resolved. But the movement in fact calls for very basic and fundamental changes in patterns of life deeply embedded in the American culture. Because of this, deinstitutionalization has "become the focus of an emotional debate" (Anonymous 1975e), which is characterized by polarized attitudes and resistance to compromise.

A SOCIOLOGICAL PERSPECTIVE ON DEINSTITUTIONALIZATION

Brown (1975) has pointed out that "the very term deinstitutionalization has become controversial, with conflicting connotations in different contexts" and that perhaps "the time has come to look for more appropriate terms." The present study, however, adopts a different position. The vagueness of the term notwithstanding, deinstitutionalization is connotative of a sociological process, and, in this sense, it is on mark. The sociologist, Kingsley Davis (1949, p. 71), has defined an institution as a "set of interwoven folkways, mores, and laws built around one or more functions." In short, an institution may be viewed in two different ways: as an established place, such as a long-term care mental hospital, or as an established set of social patterns, such as the totality of artifacts and practices society has adopted for the care of its mentally disabled population. It is in the latter sense that the term deinstitutionalization, when used in reference to the mentally ill, has greatest value. It implies the breakdown of a social system, of established patterns of social control which determine how the mentally ill should be viewed, what their status (position) in society is, what rights and obligations society has in reference to them, and what rights and obligations they have in reference to society.

In the present study, the terms institution, institutionalization and deinstitutionalization will be used primarily in the popular sense—that is, to refer to movements of patients in and out of mental hospitals. However, the terms will also be used at times in the sociological sense, as the author knows of no alternative terminology which conveys quite the same meaning. The specific usage of these terms should be apparent from the context in which they occur.

SCOPE OF STUDY

This study proceeds from the basic assumption that the promise of the deinstitutionalization movement—i.e., the enhancement of mental health services delivery through the provision of community-based facilities—can best be realized if the problems which it has encountered are recognized and acknowledged. Only through such appraisal can the problems be overcome. The basis for this work is a review of the literature concerned with the deinstitutionalization of mental patients. That review has resulted in the author's adoption of the position that not enough theoretically systematic attention has been paid to the process of deinstitutionalization. This has generated serious obstacles to the understanding of the process and of the issues related to it. Without a theoretical framework, writings have tended to contain, for the most part, a jumble of disparate facts and guesses, interspersed with strongly worded partisan stands. The resultant confusion has been sufficiently overwhelming to be counter-productive. Instead of receiving constructive criticism directed toward resolving issues in a practical way, the movement has found itself bogged down by seemingly insoluble problems.

It is the purpose of this work to describe the issues in deinstitutionalization concisely and systematically and to examine them with the assistance of a theoretical framework. The framework to be used is functionalist in nature and is based on insights provided by an anthropologist (Malinowski 1945), a semanticist (Hayakawa 1949), and several sociologists (Chinoy 1954; Crawford 1973; Johnson 1960; Merton 1957). A fundamental and underlying assumption is that many of the problems connected with deinstitutionalization are closely
related to a general failure, first, to understand and/or pay adequate attention to the unique position of the mental hospital in American culture, and, second, to make sufficient allowances for this uniqueness in the process of planning for social change.

At the conclusion of the text is a bibliography of citations from the professional and lay literature dealing with deinstitutionalization of the mentally ill and related topics. In no sense is this bibliography intended to be "complete." The body of literature is so vast and has taken such a variety of directions that any effort to include all writings would be doomed to failure. This study does, however, aim at reviewing broadly and summarizing generally the major issues treated in the literature. To this end, selections have been included in the bibliography for their relevance to points made in the text. Citations have generally been limited to writings from the past decade, but occasional earlier works have also been included in instances where they are especially relevant to, or strongly reinforce, particular points under discussion. In addition, a number of references not dealing with deinstitutionalization *per se*, but relevant to the sociological analysis of the materials reviewed, have been included in the bibliography.
II. BACKGROUND

"Characteristic of each humanitarian movement are four distinct periods. The first is a period of innovation or new ideas. This peaks rapidly after the initial outburst of enthusiasm, as the community mental health movement did between 1965 and 1970. The peak is followed by a period of criticism and then a time of retrenchment. The four periods are thus innovation, peaking, criticism, and retrenchment."

—Trevor D. Glenn, 1975

Recent years have witnessed the gradual phase-out of a number of mental hospitals and the complete closing of others, while the utilization of local community-based services has steadily increased. That there has been a growing trend toward the treatment of the mentally ill in their home communities is apparent from utilization statistics. In 1955, about half of the psychiatric patient care episodes in the Nation were in State mental hospitals, as contrasted with about one-fifth in 1971. Outpatient services accounted for only 23 percent of psychiatric patient care episodes in 1955 but for 42 percent in 1971. Federally funded community mental health centers, which did not even exist prior to the passage of the Community Mental Health Centers Act of 1963, accounted for 19 percent of psychiatric patient care episodes in 1971 (Pollack and Taube 1975; Redick 1973).

Paralleling the reduction of patient care episodes in State hospitals has been a dramatic decrease in the size of State hospital resident populations. The number of resident patients in State mental hospitals, which peaked at 558,992 in 1955, has been decreasing ever since. During a period of 9 years alone, starting with the 1963 Presidential message on mental health, the resident population of State hospitals decreased by 45 percent (from 504,604 to 275,995). One of the critical elements in this decrease has been the smaller number of first admissions aged 65 and over and the correspondingly heavier reliance on nursing home and other residential facilities for this long-stay population. Another factor has been the widespread use of psychoactive drugs in the treatment of inpatients, which has made possible greatly shortened hospital stays, as well as the release of patients who might never otherwise have been considered for discharge into the community.

At the same time that the resident population of State hospitals has decreased in size, the number of admissions to these hospitals has, in general, increased. Thus, more patients have been admitted for shorter periods of time. Although the general diagnostic distribution of the resident population at these institutions has not changed appreciably over these years—about half the resident patients have been and continue to be schizophrenic—there has been a marked change in the diagnostic composition of admissions. In 1962, for example, 21 percent of first admissions to State hospitals had diagnoses of schizophrenia, and 15 percent had diagnoses of alcohol disorders. In 1972, corresponding percentages were 14 percent and 26 percent, respectively.

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1 A number of references describe and discuss phasedowns, phasouts, and closings of State hospitals. Selected examples are: Cumming and Markson (1973); Ishiyama (1974); Keenan (1974); Khan and Kaplan (1974); Markson (1976); Markson and Cumming (1974); Marlowe (1974); McDonald (1974b); Place and Weiner (1974); Schultz, Lyons and Nothnagel (1975); Sills (1975); State of California (1973); Weiner, Bird, and Associates (1973).

2 Actually, with the year 1972, a reversal in statistical trends is noted. Taube (1974) reports that admissions to State mental hospitals during both 1972 and 1973 showed decreases over the previous years.
These statistics reflect a changing philosophy of mental health care in the United States—a philosophy which, in recent years, has undergone rapid and major revision. Outpatient care has been favored over inpatient treatment. And when inpatient treatment has been indicated, the emphasis has been in the direction of care in short-term facilities, such as general hospitals and community mental health centers, instead of long-term mental institutions.

There has been a growing conviction among many mental health professionals that the removal of the mentally ill individual from "normal home and community ties" (Schwartz 1971) reduces his chances for effective treatment. Thus, the new philosophy in mental health care embraces the goal of avoidance of hospitalization whenever possible and the "replacement of custodial philosophies by therapeutic ones" (Schwartz 1971). Because institutionalization is perceived as "banishment" (Rusk 1972)—because it is viewed as fostering regression among patients (Herz 1973)—there is a strong feeling that the provision of services on any basis other than institutionalization is superior to a hospital experience. Although access to adequate mental health services is understood to be a basic right of all individuals, these services should, ideally, be provided without exposing patients to the stigma associated with traditional custodial mental health care. In addition, the noninstitutionalized patient living in the community has the opportunity to benefit from the salubrious effects of social contact with sympathetic and supportive relatives and friends (Kramer 1967).

These philosophical principles, coupled with evidence that "hospitalization begets more hospitalization" (Schwartz 1971), lead logically to a strong commitment to the notion that the role of the mental hospital in the treatment complex must be revamped, if not eliminated. With patient care occurring in a familiar, relatively stigma-free home environment, the patient is more likely to be understood and to see himself as a participating member of his own home community, rather than as a stigmatized expatriate.

This entire philosophy is thrown into sharp relief by an emerging development—the introduction of so-called brief hospitalization units for psychiatric patients in some localities (Caffey, Galbrecht, and Klett 1971; Herz, Endicott, and Spitzer 1973; Rhine and Mayerson 1971; Schwartz 1971; Schwartz, Weiss and Miner 1972; Walker, Parsons and Skelton 1973; Yarvis 1975). Typically, these units are administratively connected with emergency services in general hospitals, although they may be tied to other services. They admit patients for brief stays rarely exceeding 4 or 5 days, during which a judgment is made regarding further disposition of the case—that is, discharge or transfer to an inpatient facility. Patients who are discharged directly from these units may to some extent avoid the stigma associated with psychiatric hospitalization, as they frequently are technically not counted as having occupied psychiatric beds.

Changes in service delivery philosophy have, of course, not occurred in an ideological vacuum. To the contrary, they may be understood as having had what might be called a natural history of their own: they have come about as logical responses to what may simply be labelled "the times." Feldman (1974) aptly points out that changes in treatment patterns have occurred "not because our patients are really any different, but because we are." In short, there has in recent years been a strong civil libertarian emphasis on the rights of mental patients (Schmolling 1975; Slovenko and Luby 1974).

Hersch (1972) provides a penetrating discussion of the ideological bases of deinstitutionalization. He points out that, typologically, "the times" may be characterized in one of two ways—either as an era of social-political conservatism or as an era of social-political reform. The former favors a view of problems as having their bases in individuals, while, in the latter, the locus of problems is the environment. Accordingly, in the former case, emphasis for amelioration is on changing the individ-

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¹ There is a substantial amount of statistical evidence for this generalization. Selected examples are provided in: Anthony et al. (1972); Buell and Anthony (1973); Fontana and Dowds (1975); Franklin, Kittredge and Thrasher (1975); Rosenblatt and Mayer (1974). Kirk (1976) provides an interesting perspective on readmission statistics in his report of a study of Kentucky State hospital discharges. He finds that patients receiving no aftercare community services and those receiving substantial aftercare community services are the least likely candidates for readmission. He concludes: "Aggregating all of those who received aftercare apparently obscures the fact that those who receive some, but not much, aftercare, are the ones with the highest re-admission rate."

² Selected additional references which amplify the ideological forerunners of the deinstitutionalization movement are: Felix (1964); Joint Commission on Mental Illness and Health (1961); Macht (1974); Rubins (1974a); Scheel (1974); Schwartz and Schwartz (1964).
ual; in the latter case, greater weight is placed upon modifying the environment.

The deinstitutionalization movement is clearly the outgrowth of an era of social-political reform. Greenblatt (1975) writes of the “rise of social psychiatry” during the second half of this century, which is reflected in “planning for ways and means of serving all the citizens...without regard to race, color, creed, or ability to pay.” To illustrate Greenblatt’s point, consider this quotation from a recently released position paper prepared by the Director of the Horizon House Institute (Rutman 1976, p. 2):

Several basic issues underlying the concern for community-based—as opposed to institutional—care for the mentally disabled should be noted at the outset. First, a major proportion of all persons now in mental institutions, or those who will be hospitalized in the future, neither need nor benefit from long-term extended inpatient care. Second, there is reliable evidence that patients who remain in institutions for extended periods experience a variety of debilitating effects, and that the cumulative results of long-term confinement—a condition or state often referred to as institutionalization—is more damaging to the individual’s mental health and well-being than the problem which required entering the hospital in the first place. Finally, for large numbers of present and future hospital patients, return to normal social functioning can only be accomplished if there are developed a variety of community-based residential facilities which can provide an atmosphere in which such persons can feel secure and accepted by peers, can improve skills of daily living, and can be helped to find their niche in the normal environment.

However, dominance of a reform ideology in a democracy does not preclude the strong co-existence of a conservative ideology. Steinhardt (1973), in pointing this out, asks whether the pendulum may not have swung too far in the direction of community care. He writes:

The original theme of keeping patients at home whenever possible has become ritualized into keeping patients completely out of the state hospitals, and even keeping them out of any mental hospital. Unfortunately, there are times when patients need to be hospitalized, whether in a state hospital or elsewhere.

Rieder (1974) states:

The State mental hospital system, and the patients in it, are in danger of being “phased out” without an effective alternative source of care being available. It is a ridiculous abrogation of our responsibility if psychiatrists and other mental health professionals allow the existing poor treatment of mental patients to be replaced with something even worse.

POLARIZATION: OPPOSING VIEWS

The most cursory examination will show that the literature abounds with horror-story descriptions of the conditions of life inside mental hospitals. Not only have the physical conditions in these places been assailed, but so has the intense dehumanization—the “feeling that one is isolated from others and is regarded as a thing rather than as a person” (Leventhal 1975, p. 20)—experienced by the patient. Perhaps more penetratingly than any other recent writer, Rosenhan (1973), in summarizing the experiences of eight pseudopatients at 12 different mental hospitals, has painted a grim verbal picture of the depersonalization experienced by the patient in the mental hospital:

Powerlessness was evident everywhere. The patient is deprived of many of his legal rights by dint of his psychiatric commitment. He is shorn of credibility by virtue of his psychiatric label. His freedom of movement is restricted. He cannot initiate contact with the staff, but many respond to such overtures as they make. Personal privacy is minimal. Patient quarters and possessions can be entered and examined by any staff member, for whatever reason. His personal history and anguish is available to any staff member (often including the “grey lady” and “candy striper” volunteer) who chooses to read his folder, regardless of their therapeutic relationship to him. His personal hygiene and waste evacuation are often monitored. The water closets may have no doors.

Rosenhan continues, “At times depersonalization reached such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account,” and provides this episode to illustrate his point:

A nurse unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men. One did not have the sense that she was being seductive. Rather, she didn’t notice us.

Similarly, one finds daunting descriptions of the plight of deinstitutionalized mental patients who are residing in the community. A strongly worded
and urgent statement is presented by Slovenko and Luby (1974):

Mental patients are going from the frying pan into the fire. Under the guise of civil liberties the state mental hospital has been transported to the inner city. It is true that many persons in institutions have been dehumanized through neglect and the failure of society to meet their needs, but the second wrong of turning them back into a so-called community will not make a right. In today's world, neglect in the community dwarfs neglect in hospitals.

An example of what Slovenko and Luby mean is described in a paper by Wolpert, Dear and Crawford (1974), who write about the fate of deinstitutionalized patients in a section of San Jose, California, where approximately 10 percent of the population is composed of "discharged patients who are indolent and living in board and care facilities." The authors state:

While there is little or no evidence to suggest that the residents are mistreated or exploited by the operators [of the residential facilities], there is ample evidence of inadequate community facilities for their further rehabilitation, recreation or other support systems. At least half of the residents are not employable and their daily routine largely involves confinement to their home watching television and drinking beer. Some of those who are employable have found employment or do become involved in county, religious, university or other volunteer programs which have been set up for their use. They may be seen walking in the streets, sitting in the laundromat or cheap cafes, and some are recognizable by the characteristic "drug shuffle," bowed head and shabby appearance.

Other writers—for example, Anderson (1974); Becker and Schulberg (1976); Chu and Trotter (1974); Greenblatt and Glazier (1975)—report evidence of the financial exploitation of expatriates by community caretakers with whom they come into contact.

In short, the deinstitutionalization movement has, since its inception, been characterized by a polarization in attitudes—a process not unusual in circumstances where social change involves issues with emotional overtones. A description of the polarization process is found in sociological theory:

Necessarily public issues tend to be phrased in dichotomous terms—e.g., war or peace, protection or free trade, prohibition or saloons, freedom or slavery. This does not mean that each problem has only two facets but simply that public action can best be mobilized, a denominator most easily struck, when there are only two sides. The most common formula is the "for or against" statement. Often the individual is not on either side in a completely unqualified sense, but the heat of public debate and the necessity of mass action reduce the problem to its lowest common denominator, the simple dichotomy. Each pressure group tries to phrase the issue in a way that will marshal sentiment on its side. The final solution of the issue is often one that practically nobody actually desires but which represents the ultimate outcome in the struggle of conflicting pressure groups—a struggle in which the weapons of distortion, intimidation, censorship, misinformation, and irrelevancy play important parts. (Davis 1949, p. 359.)

Thus, Reding (1974) expresses this polarized view in a letter to the Psychiatric News:

The rehabilitation of human warehouses, euphemistically labeled "state hospitals," is a hopeless task, thank God. Adding good psychiatrists to such institutions is like pouring good wine into a bad barrel. There is only one way to deal with state hospitals or, for that matter, with prisons: empty them, close them, then blow them up, because, as is well known, state legislators cannot tolerate empty buildings. Then only shall we psychiatrists be cornered into honoring our Hippocratic oath and our social obligations. Then only can we be expected to go help the local communities take care of their own human problems instead of storing them out of their sight and ours.

And Mendel (1974a), in a paper presented at a conference on the closing of State mental hospitals, concludes with this statement:

Since the hospital as a form of treatment for the severely ill psychiatric patient is always expensive and inefficient, frequently antitherapeutic, and never the treatment of choice, it behooves us now to develop a strategy and timetable for dismantling the mental hospital.

Dingman (1974) counters these observations:

1. State mental hospitals ought never to have been established.
2. They do exist and we have encouraged dependence upon them.
3. Suitable facilities to which to transfer the dependence do not exist at this time.
4. CMHC's [comprehensive community mental health centers] are inheriting many of the defects of state mental hospitals and, therefore, there is little point in planning to transfer functions to them.
5. Closings on any major scale are unthinkable.

DEPOLARIZATION: MODERATION OF VIEWS

It is really only in the very recent literature that substantial tempering of polarized stances begins to become noticeable. Although, of course, some earlier writers adopted moderate viewpoints, it is primarily in the literature of the mid-1970's that the compromising of extremes has become dominant. It is now increasingly recognized and acknowledged that earlier diatribes against mental hospitals might have been unfair simply in their failure to acknowledge that these facilities do not necessarily nor uniformly fit the grim picture of dehumanization described earlier. In addition to what may be characterized as humane care, many mental hospitals, in fact, offer innovative and experimental programs and some provide as complete a range of services as those found in community mental health centers (Horizon House Institute 1975b; Jones 1975; Keedward et al. 1974; Kramer and Taube 1973; Landor 1976; Rosenblatt and Mayer 1974; Schapire 1974; Stubblefield 1976a; Texas DMHMR 1975).

Now, instead of partisan statements seeking to denigrate all alternatives, a continuum of treatment alternatives is proposed. Now, statements that acknowledge frankly that the world of mental health services has a place for both institutional and community-based facilities are becoming popular, and there is a strong call for co-existence. Barnett (1975, pp. 274–275), speaking more globally of health services in general, states that there must be:

... a variety of approaches in health delivery to meet the variety of responses in the population to be served. The question no longer is: "How can we humanize the system?" Rather, it is: "What is the best procedure for what kind of patient?" Once there is variety, informed choice becomes possible for the patient. We should not fall into the trap of prescribing a new monolithic system for the present, no matter how "humanized" the new system may appear. A monolithic system (i.e., one without variety and choices) cannot be a humanized system.

This view is clearly shared by many concerned specifically with mental health services. The Executive Committee of the American Psychiatric Association has released a position statement declaring the need to retain chronic care facilities (Anonymous 1974b):

While we applaud the trend toward the growing adequacy of community resources and the concurrent reduction of the patient population in public mental hospitals, we now view with considerable concern the trend toward the phasing out of the capacity for providing long-term inpatient care and treatment for the mentally ill or disabled.

The APA statement cites as a major reason for this position that "pressure to discharge patients from the public mental hospital too often results in discharging patients without adequate planning, which in turn results in their living in substandard and dehumanizing circumstances." A Senate Select Committee of the California Legislature has sought to abandon earlier plans to phase out all State mental hospitals; it is now proposed that hospitals be integrated into local service delivery systems (State of California 1974).

De la Torre (1973) points out that "one should keep in mind that prevention of hospitalization is a means and that the prevention or amelioration of psychiatric illness is the real end." Nowhere is the newly emerging broad awareness of the need for a range of services including the mental hospital better expressed than in a paper presented by the British psychiatrist, John Wing (1975):

The quality of life lived by the patient and his relatives is the final criterion by which services must be judged. A good hospital is better than a poor hostel or a poor family environment. A good family environment is better than a poor hospital or a poor hostel. The same may be said of day-time environments—open employment, enclaves in ordinary commercial business, rehabilitation or sheltered workshops, or protected day centers. Universal denunciation of any one type of setting is likely to be harmful since it is clearly not based on rational principles of assessment, treatment or care.

Current writings on deinstitutionalization appear also to be considerably less emotional in tone than the earlier treatises. Now, some of the affect

*Selected additional references illustrating the emerging depolarization in viewpoint include: Mechanic (1975b); Ochberg (1975); Reich and Siegel (1973); Smith and Hart (1975).
has been tempered by practical experience. Whereas earlier statements were based on untested assumptions, and "oversimplifications served as the rocks upon which programs were sometimes hurriedly built" (Black 1974), today's viewpoints are grounded in a decade and more of reality (Goldman 1976). The deinstitutionalization movement now possesses a history, however brief (Anonymous 1976d), and many current positions are the result of experience.
III. SUMMARY OF ISSUES IN DEINSTITUTIONALIZATION

"But what kind of crusade is it to condemn sick and fearful people to shift for themselves in an often hostile world; to drag out, all too commonly, a hungry and derelict existence in a broken-down hotel if they are lucky; victimized, if they are not, by greedy operators of so-called halfway houses that are sad travesties on a fine concept? All without their even knowing the possibilities of new medical approaches to their illness—and all in the name of civil liberty."

—New York Times Editorial, April 8, 1975

Four recent articles appearing in journals have, in the view of this author, contributed greatly to summarizing the issues in deinstitutionalization and elucidating the critical nature of these issues. A very readable work by Kirk and Therrien (1975) examines issues in deinstitutionalization with a view toward exposing the "myths" which have surrounded the movement. A second article, by Greenblatt and Glazier (1975), serves further to amplify issues by focusing on some of the shortcomings in treatment at community-based facilities and on the general paucity of information available on which to base program plans. This reference is especially valuable for its clarity. A third article, by Becker and Schulberg (1976), appears in a nonpsychiatric medical journal. Entitled "Phasing Out State Hospitals—a Psychiatric Dilemma," its very placement in the coveted "Special Article" spot in the prestigious New England Journal of Medicine attests to the importance of the deinstitutionalization movement. This reference underscores the fact that the controversy concerning deinstitutionalization is no longer confined to the fraternity of mental health workers, nor even the popular press; even the greater medical community now feels constrained to review the issues. Finally, a sociological "case history" of a single state hospital (Fowlkes 1973) provides insights into the "structured resistance" to change in the world of mental health service delivery.

Together, these four articles give to the deinstitutionalization movement a well-deserved aura of importance and immediacy. They say, in no uncertain terms, that: (1) the issues in deinstitutionalization movement are manifold, complex and serious; (2) the issues cannot be resolved by rhetoric; and (3) the time has come to evaluate these issues on a conceptual level in order to make them more comprehensible and more responsive to ameliorative efforts.

It is not the intention of the present study to rehash the issues in deinstitutionalization in detail. This has been done frequently, and often with great skill; and doing so here would merely be repetitious. It is, however, important to present some kind of taxonomy of these issues, short of detailed elaboration. This the present work attempts to do. Such an endeavor is by its very nature selective. So many complex problems have been cited, and there is so much overlap, that the mere selection, enumeration, and ordering of problems must reflect the biases of one who classifies them. Their specific ordering here results from the theoretical perspective employed, which will be detailed in the next section of this study.

The issues summarized here will be presented concisely. References to citations which amplify them will be provided. In addition to those issues which are dealt with directly in the literature, this study will discuss other issues, rarely labelled as such but apparent from a review of current writings—sometimes as much from a lack of systematic attention (as in the case of the problem of the views of institutionalized patients themselves toward deinstitutionalization) as from an examination of the elements involved.
A TAXONOMY OF THE ISSUES IN DEINSTITUTIONALIZATION

The issues in deinstitutionalization appear to fall into eight major groupings as follows: Issues related to the selection of patients for community care; issues related to the treatment course of patients in the community; issues related to the quality of life of patients in the community; issues related to the greater community; financial and fiscal issues; legal and quasi-legal issues; informational issues; and additional issues resulting from the process of deinstitutionalization itself.

It cannot be too strongly emphasized that the issues presented here are separable only in theory. They are completely intertwined, and artificial separation of them at this time is made only for taxonomic purposes. Their ubiquitous interdependence should become apparent to the reader as he proceeds through the narrative supporting the catalogue of issues. In short, the system of care of the mentally ill in this society is institutionalized (in the sociological sense) and hence is characterized by an integration of its elements. Any specific element in the system is in many ways and by a variety of routes related to any other element, and a change affecting one element precipitates changes in all others. Thus, whether a specific problem in the deinstitutionalization movement—such as the limitations on physical mobility which many patients experience in the community—is classified under the second, third, fourth, or some other category mentioned above is a moot question. Theoretically, the problem belongs in all categories, and the specific assignment on paper is a matter of the author's discretion in judging where its placement seems to be most apt.

THE ISSUES EXAMINED

I. Issues related to the selection of patients for community care:

A. Chronically ill patients—According to Mechanic 1975b, p. 5), "one of the adverse consequences of the expansion of mental health concepts in the 1960's was the redirection of attention from the needs of the psychotic patient... Community mental health centers had diffuse missions and found it easier—and perhaps professionally more rewarding..."

B. Patients inadequate prepared for life in the community—Place and Weiner (1974, p. 46) report from a followup study of patients released from Napa State Hospital in California, that "the most glaring deficiency of mental health services is the lack, if not total absence, of programs designed to provide discharged patients with the practical skills needed to function in an ordinary community." Similarly, Anthony et al. (1972) conclude that although "inpatient treatment innovations improve the patients' in-hospital behavior... the research does not indicate that these approaches can singularly effect posthospital adjustment." Since long-term chronic care tends to "foster social and economic dependence" (Roth 1970, p. 61), it "creates norms and behaviors which reinforce the dependent role of the patient, [and] these behaviors are frequently at odds with those needed to survive successfully in the community" (Rutman 1976); re-entry into the community may thus prove extremely problematic for some former patients (Jansson 1975). Adjustment may require the establishment of "meaningful new social statuses" defining the position of former patients in the community (Sanders 1974). Stubblefield (1976a) refers to a related problem: placement of rural patients in urban aftercare settings as the result of "limited to nonexistent" resources in their home communities. Such "transplants" experience heightened psychological and social burdens in rehabilitation.

C. Disadvantaged and minority groups—Wecluw

*Numerous references deal with the plight of chronically ill patients in the community. Selected examples include: Becker and Schulberg (1976); Crane (1974); Falk and Murphy (1976); Hogarty (1971); Lamb (1970); Reich (1973); Reich and Siegel (1973); Whittington (1969).
(1975) contends that community-based services tend to be irrelevant to the needs of Latino patients and that this results in their underutilization of such services. Mayo (1974) points out similar problems in the community treatment of blacks. Other studies deal with difficulties in providing relevant treatment to rural patients, to elderly patients (Anonymous 1976; Becker and Schulberg 1976; Flashner, Engadela and Alderman 1974; Hicks 1976; Muskie 1974; Redick 1973), and to patients of low socioeconomic status. Myers and Bean (1968) assert that "adjustment in the community is most difficult for lower-class patients." A common denominator in these observations dealing with disadvantaged and minority groups appears to be that community treatment needs to be tuned in to the cultural needs of the patients which it serves. It must be more aggressive than hospital-based treatment: patients in the community must be attracted in such a way that they will voluntarily utilize the facilities.

II. Issues related to the treatment course of patients in the community:

A. Inadequate range of treatment services—The range of treatment services available to patients in the community must be expanded and elaborated (Rutman 1976). Kirk and Therrien (1975) indicate that there is a "lack of knowledge about what would constitute an effective and inexpensive treatment [for former mental patients]... The only partially effective treatments are the psychotropic drugs, but these are clearly only a first step." Rosenblatt (1975) proposes the formation of nontherapy-oriented custodial care facilities in the community. Roussin (1975), however, argues for more direct patient treatment which "is not even a part of some community mental health programs." Allen (1974), a former patient, writes:

Regardless of what treatment programs exist in the community, they surely are not providing enough therapy. I myself see many, many people who, so far as I can tell, are untouched by any-

* Numerous references deal with the special needs of mental patients residing in rural areas. Selected examples include: Bentz, Edgerton and Hollister (1971); Brown and Taylor (1966); Buxton (1973); Cody (1973); Edgerton and Bentz (1969); Gertz (1974); Gertz, Meider and Pluckham (1973); Greene and Mullen (1973); Guillozet (1973); Gurian (1971); Hollister (1973); Kraenzel and Macdonald (1971a); Kraenzel and Macdonald (1971b); Lee, Giaturco, and Eidorter (1974); Proctor (1973); Taylor (1973); Torino (1975).

thing that resembles treatment... I believe the majority of board and care residents live in an isolated, removed, seldom-changing, untouched world. There is a very real possibility that yesterday's back wards of State mental hospitals are becoming today's board and care homes.

B. Fragmentation and lack of coordination in community treatment services—Community-based mental health services are frequently lacking in centralized administration, and this results in fragmented responsibility. Relevant agencies do not have open lines of communication. Kirk and Therrien (1975) suggest that community-based services need to have "a single agency or person acting as sole agent or advocate for the patient or having primary responsibility for seeing that...[his] many needs are adequately met." The issues of fragmentation and lack of coordination are among the most widely and heatedly discussed in the literature. Selected references dealing with these issues include: Gittelman (1974); Grenny and Crandell (1973); Horizon House Institute (1975b); Rutman (1976); Zehr (1969).

C. Inaccessibility of treatment services—Community services may prove to be less accessible to mental patients than hospital-based services in a variety of ways—e.g., limited business hours at service facilities, or greater time, distance, and financial resources required to travel to such facilities. Feldman (1974) lists three components of accessibility: geographic, financial, and psychological. With respect to psychological accessibility, it is necessary that community care be aggressive; it cannot be assumed that because treatment facilities exist, patients will automatically utilize them (Davis, Dinitz and Pasamanick 1972). Discussions of accessibility issues are found in Feldman (1971), Mannino, Rooney, and Hassler (1970), and Mechanic (1975a).

D. Questionable quality of care in community services—The limited range of available services, the fragmentation of services, the inaccessibility of services—as well as the precipitate manner in which community service networks have sometimes come into being—combine in such a way as to raise serious doubts concerning whether patients are getting optimal treatment (Allen 1974; Hoshall and Friedman 1975). Special objections have been raised by some writers to what is considered disproportionately heavy reliance on psychoactive drugs—sometimes to the exclusion of other treatment modalities—in the community. See, for example, Crane (1974), and Scheff (1976).
III. Issues related to the quality of life of patients in the community:

A. Inadequate community support systems—For all persons, “successful functioning depends on the material assistance and emotional support we receive from our fellows” (Mechanic 1975b). Such supports are frequently unavailable to mental patients residing in the community, often as the result of the very special psychological and interpersonal difficulties that characterize them. “Without well-organized and aggressive [community support] services . . . patients are often lost in the community and eventually end up in difficulty” (Mechanic 1975b). Accessibility is also a problem in community support systems. These systems are needed to assist noninstitutionalized patients in those areas of life where friendly intervention and a helping-hand are frequently needed—e.g., the development of friendship networks, the seeking out of employment opportunities, and the organization of leisure and social activities. Sometimes support systems are needed to assist patients in areas related to treatment—e.g., in setting up of appointments and transportation to therapy sessions.

B. Residential facilities and living arrangements—“The first obstacle faced by every state hospital system which wants to close down is what to do with the large number of patients currently hospitalized, some of them hospitalized for many years. Many of these patients have neither family who want them nor financial or social resources to secure adequate housing” (Kirk and Therrien 1975). Clearly, noninstitutionalized patients cannot always live “at home.” Kramer (1970) outlines these underlying assumptions which are “central to the expectation that patients can be kept in their homes”:

1. Patients have a home. 2. Patients have a family or other persons who are willing to assume responsibility for them and are well enough and financially able to provide the necessary care. 3. Patterns of organization and interpersonal relationships in the patient household are such as not to impede or prevent the recovery or rehabilitation. 4. The family has sufficient understanding of the patient’s illness and expected behaviour so as to develop attitudes which assist rather than retard recovery and rehabilitation. 5. The patient’s behaviour and his needs are such that his presence in the household does not produce undue hardships for the other members of the household and does not precipitate secondary attacks of disease and disability in the other members. 6. Appropriate medical, psychiatric, nursing, social work and related services are readily accessible to meet the changing needs of the patient and his family.

Although the various alternative living arrangements such as halfway houses, homes for the aged, boarding homes, nursing homes, residential hotels, etc., which have been designed for the housing of mental patients in the community, have often [in specific instances] been found adequate and even preferable to hospital residence, most reports indicate that on a widespread basis they usually have fallen short of the desired goal of providing a humane environment.

IV. Issues related to the greater community:

A. Community resistance and opposition to mentally ill individuals—This is a much discussed issue in the literature. There appears to be consensus that society has difficulty in dealing with the presence of mental patients in their midst. Kirk and Therrien (1975), in discussing patients discharged from mental hospitals, summarize the position: “Former patients are not welcomed back into communities with open arms; instead they are often confronted by formal and informal attempts to exclude them from the community by using city ordinances, zoning codes, and police arrests.” They conclude that “Residence in the community can be just as disabling, frightening, dehumanizing, and isolating as living in the wards of more formally structured institutions.”

B. Effects on communities to which patients are released—in urban areas, services for deinstitutionalized mental patients tend to be concentrated in certain neighborhoods, and “a highly visible and significant new problem has evolved . . . in the selective concentration of a variety of service fa—

10Numerous references deal with the problems of living arrangements and residential facilities within the community. Selected examples include: Bachrach (1975b); Brodsky (1968); Cummimg (1975); Davis, Dilzit, and Pasamanick (1974); Dey and Steele (1975); Edelson (1975); Heine, Yudin, and Perlmuter (1975); Kramer and Taube (1973); Lamb and Goertz (1971); Mannino and Shore (1975); Miller (1975); Muskie (1974); Robbins and Robbins (1974); Schulberg, Becker, and McGraw (1975); Sheppard (1976); Thompson (1975).

11Numerous additional references deal with the issue of community resistance and opposition to mentally ill persons. Selected examples include: Anonymous (1975a); Aviram and Segal (1975); Farina et al. (1974); Greenblatt and Glazier (1975); Horizon House Institute (1975); Lowinson and Langrod (1973); Ochberg (1974); Orndoff (1975); Piasecki (1975); Rattan (1975); Segal (1975); State of Michigan (1974); State of New York (1976).
ilities in certain neighborhoods, to a point of possible community saturation" (Wolpert 1975b). Some effects of this problem are the diminishing of real estate values and out-migration of the resident population. There are other kinds of problems in rural areas. Population sparsity creates problems in absorption of deviants. A special problem of increasing numerical significance in rural areas, not as yet reported in the published literature, is explained by R.D. Morrison (1976), who refers to the "tragic recruitment into the migrant labor stream of prematurely or inappropriately discharged mental patients who relapse under the strain of migrant existence and become expensive charges" of the Commonwealth of Virginia.

C. Ecological impacts on economy of hospital community and on hospital staff—The economic structure of communities in which large mental hospitals are located may be entirely dependent on the existence of the hospital. Dingman (1974) asserts that "dozens of towns in the United States owe their existence entirely or principally to a state hospital. In many dozens more localities, the state hospital has provided the largest single source of demand for the development of supply systems, educational systems, and so on. The ecological impact of a state hospital closing is unassessable—staggering—incredible in its proportions. The fact that we have no notion as to how to meet our obligations to these communities does not make the obligation go away." In addition, there is evidence that the closing of mental hospitals has adverse effects on the morale of staff (Greenblatt 1974; Ishiyama 1974; Khan and Kaplan 1974; Schultz, Lyons, and Nothnagel 1975; Weiner, Bird, and Associates 1973; Whittington 1969) who are concerned with their chances for alternative employment (American Federation of State, County and Municipal Employees 1973; Anonymous 1975e; Anonymous 1976e; California State Employees’ Association 1972; Feldman 1974; Horizon House Institute 1975b; Weiner, Bird, and Associates 1973). The morale factor, in turn, may affect the quality of patient care provided during the period when the hospital is preparing to close.

D. Effects on patient’s family—"Returning patients to their families," says Doll (1976) "is, of course, a logical step in the deinstitutionalization movement. And yet as progressive as that movement is, it may be causing serious crises in the lives of those families who are now responsible for the care and rehabilitation of relatives released from mental hospitals." Arthur (1973) claims that the "question of whether there are long-term subtle deleterious effects on other family members has yet to be resolved." A report by Doll (1976) indicates that even in the short-run, the patient’s presence at home may put severe emotional and social strain on other family members, and he argues that if "family crises are severe enough, the trend toward community care may have to be reversed and permanently replaced by institutional care." Slovenko and Luby (1974) assert simply that "it is not to be forgotten that the family too is to have rights." 12

V. Financial and fiscal issues:

Numerous references deal with the financial and fiscal problems associated with community care.13 Opinion concerning the cost-benefits of community over hospital-based care is divided, but there seems to be consensus that the deinstitutionalization movement is encountering substantial fiscal problems. In fact, according to Kirk and Therrien (1975), the knowledge required to make accurate cost assessments is simply not available. They refer to "the transfer of major fiscal responsibility ... from the mental health facilities to the public welfare enterprise," and conclude that "no one knows the magnitude of these hidden costs of community mental health or how they compare with the costs of hospitalization." Among such hidden costs are the "indirect costs incurred by other community agencies that are called upon to deal with the patients"—e.g., police, courts, emergency rooms, family agencies, etc. (Kirk and Therrien 1975). Arnhoff (1975) suggests that, after considering these intervening variables, the "actual cost-benefits of community treatment ... are far less than its advocates proclaim."

VI. Legal and quasi-legal issues:

Ennis (1975, p. 83) writes (reprinted by permission of the publisher, Lexington Books, D. C. Heath and Co.):

Courts have always been concerned to some extent with the legal rights of persons facing in-

12 Other references dealing with the effects of deinstitutionalization on patients’ families include: Arnhoff (1975); Creer and Wing (1974); Cumming (1975); Doll, Thompson, and Leifson (1976); Falk and Murphy (1976); Heine- mann, Yudin, and Perlmuter (1975); Hill House (1975); Robbins and Robbins (1974); Strauss (1975).

13 See, for example: Maht (1974); McClintock (1975); Murphy and Dextel (1976); Peterson (1978); Sharfstein and Nafriger (1976); Sheehan and Atkinson (1974).
voluntary commitment to a state institution for the mentally ill or mentally retarded. But until very recently courts have refused to look behind institution doors. It is, literally, only in the past five years that courts have begun to consider the rights that patients retain inside such institutions once they are there lawfully. The rights that have become the focus of that examination include the following: the right to treatment; the right to refuse treatment; the right to protection from harm; the right to be paid for institution-maintaining labor; the right to be treated in the least restrictive setting and in the least restrictive and intrusive manner; the right to a free lawyer to resolve problems resulting from and problems separate from institutionalization; the right to a nonrenewable limitation on the permissible period of involuntary institutionalization; the right to decent living conditions— including the right to regular outdoor exercise, adequate clothing, and adequate medical care; the right to a public education regardless of the degree of mental handicap; and the right to meaningful notice—not just notice, of these and other rights.

With the deinstitutionalization movement, concern about these rights has followed patients as they have re-entered and/or taken up residence in the community. Legal and quasi-legal issues in deinstitutionalization are extremely complex and have increasingly been the subject of a number of excellent and informative treatises. In addition, such issues increasingly are becoming the subject of concern in lay publications. One major focus in this area, which has lately become the target of vigorous debate, is the matter of “dangerousness.” Zitrin (1976) reports that records of discharged patients from the Bellevue Hospital catchment area show criminal arrest rates, including rates for violent offenses, that are higher than corresponding rates in the community. Langley, Barter and Yarvis (1975) assert that “mental health professionals are not good predictors of dangerousness”; Dix (1976) conurs in this view. Perhaps in this particular problem lies a substantial portion of the explanation for the emotional and polarization surrounding the entire question of deinstitutionalization.

VII. Informational issues and accountability:

A. Necessity for evaluation studies—Effective and conclusive research has lagged in the deinstitutionalization movement. Even the extent to which community-based facilities and mental hospitals tend to serve the same—or different—patient populations, is not yet known: Reports on this matter show conflicting results. In order for realistic and effective program planning to take place, it is first essential to identify the population which is to be served and then to ascertain whether the target group(s) are being reached (Bachrach 1975a). It is also necessary to have ongoing evaluation studies to provide the feedback necessary for planning and implementing modifications in programs already in process (Glenn 1975; Goertzel 1976; Hargrove 1970; Matlins 1975; Schapire 1974; State of New York 1976; Yudin and Ring 1971; Zusman 1971; Zusman and Ross 1969).

B. Difficulties in locating and following patients in the community—Many of the followup studies already conducted have shown substantial percentages of released patients who could not be located in the community. Thus, many followup studies are based on samples which are biased by the exclusion of patients who could not be contacted. The inability to locate individuals for followup studies is, of course, a reflection of the inability to locate them for purposes of pursuing prescribed treatment courses.

C. Inadequacy of existing followup studies—The question of what actually happens to patients who leave mental hospitals and re-enter the community is largely unanswered. Although many followup studies with varying degrees of sophistication in

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14 See, for example: Aanes, Klaesey, and Wills (1975); Arthur Bolton Associates (1975); Beckoven and Solomon (1975); Dyck (1974); Kenisnith. Nenninger and Coyne (1975).

15 See, for example: Anonymous (1975a); Bristow, Harris and Henderson (1968); Horizon House Institute (1975a); Place and Weiner (1974); Wiggins (1970).

16 Numerous references deal with the difficulties of tracking mentally ill patients in the community. Selected examples include: Bachrach (1972); Bachrach (1972c); Bachrach (1976); Feldman (1974); Kedward et al. (1974); Kramer (1970).
design are reported in the literature, their results are largely inconclusive in any broad sense. For the most part, these works have very limited replicability and generalizability (Bachrach 1976a). There is a need for more followup studies of mental patients after their release into the community (Kedward et al. 1974; Rosenblatt and Mayer 1974); and these studies should have comparability and generalizability in order that meaningful decisions regarding community-based care can be made. In short, "we need accurate, standardized information regarding our present systems of care in order to make just and rational decisions regarding future allocations of scarce mental health resources" (Greenblatt and Glazier 1975).

VIII. Additional issues resulting from the process of deinstitutionalization itself:

A. Timing: precipitate implementation of new programs—Deinstitutionalization has often proceeded with such rapidity that there has hardly been time to plan carefully for community-based programs with a view toward meeting special needs and overcoming special problems of target groups. Issues of acceptability and accessibility of services have often been overlooked in the haste of implementing new programs.

B. Inadequate attention to patients' desires—A thought-provoking article by Mayer and Rosenblatt (1974) points out that "the opinions of mental patients traditionally have been ignored by mental health researchers, although they are most relevant if patient care is to be improved. A comparison of patient and staff opinion reveals that patients have a more positive view of the hospital, and disagree with staff in their conceptions of what makes patients 'get better'." Herjanic, Stewart and Hales (1968) caution that a successful community program must "be satisfactory to the patient." Although some investigators approach or attest to the importance of this area of concern, the problem is distinguished more by oversight than by prominence in the literature.

C. Problems related to providing adequate services in hospitals during phase-out—This issue is summarized in a statement by Kram (1975): "It is unrealistic to expect a hospital to function at its best in the midst of funding cutbacks or after a decision has been made to close it." Staff morale and uncertainty about the future become matters of concern in this connection.

D. Failure to establish liaison between hospitals and community-based facilities—Inexorably tied up with the problem of inadequacy of followup procedures is a situation wherein deinstitutionalized individuals must sometimes fight their way through massive red tape in order to be treated in the community. A former patient makes this observation: "Sometimes it seems as if the mental health care system has become so complex that one needs a college degree just to be a patient" (Hoshall and Friedman 1975). This problem is closely related to the fragmentation of community services and to the failure to provide adequate community support systems as described above.

E. Role-blurring—Mental hospitals have a notable advantage over more loosely structured community-based facilities in that, at the former, the social structure is more clearly defined. There is an easier understanding of statuses and roles—of who does what for or to whom and in what contexts. Some may object to the actual normative content of the statuses in hospitals, but at least the definitions are there and are relatively clear. When patient care is transferred out to the community, traditional definitions no longer seem to work, and anomie—a "social condition characterized by a general breakdown, or absence of norms governing group and individual behavior" (Hoult 1969, p. 21)—results. Thus, Sanders (1974), who writes that "it is quite obvious that the chronic mental patient does establish and generally maintains a stabilizing role in the hospital, which is something he has not been able to accomplish in the community, even on a minimal level," connects such role-blurring with high recidivism. Not only does role-blurring occur among patients, but it also occurs among staff members in the community. Ochberg (1976) attributes this situation to the existence in the community of "curious and creative people discovering ways to use their skills in new settings" and anticipates that the confusion

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39 See, for example: Anthony et al. (1972); Davis, Diniiz, and Pasamanick (1975); Davis, Diniiz, and Pasamanick (1974); DiScipio (1973); Fakhruddin, Manjooran, and Nair (1972); Franklin, Kittredge, and Thrasher (1973); Grenny and Crandell (1979); Herjanic, Stewart, and Hales (1968); Lafave, Stewart, and Grunberg (1968); Lamb and Goertzel (1972b); Martin and Sterne (1975); McClintock (1975); Michaux et al. (1988); Myers and Bean (1968); Place and Weiner (1974); Singer and Grob (1973); Wiggins (1979).

40 Selected references dealing with the problem of timing include: Becker and Schulberg (1975); Easton (1974); Glenn (1975); Jones (1975); Robbins and Robbins (1974).

41 See, for example: Mechanic (1968, p. 89); Sanders (1972); Wanberg, Horn, and Fairchild (1974).
has, since its inception, confronted obstacles every step of the way. It is almost as if it has been on a collision course, encountering roadblocks at every turn and creating new barriers in the process of trying to remove old ones.

One of the ironies that strikes the student of deinstitutionalization is that the issues discussed here are not necessarily newly revealed. One can only speculate as to whether the problems which the movement faces today are inevitable consequences of social change, or whether some of these problems might have been avoided or mitigated had more notice been taken when they were first mentioned in the literature. Kramer et al. (1956), for example, wrote as long as 20 years ago:

So that we may really be able to assess what a course of hospitalization has accomplished, we need answers to questions such as the following: of patients who have been returned to the community, how many relapse and how soon? How are relapse rates related to diagnosis, sex, age on admission, length of hospitalization, therapy? What social and environmental factors encountered by discharged patients are related to relapse or successful readjustment? Accurate follow-up data on discharged mental patients can serve as the basis for "discharge prediction" techniques, weighting significant factors in the patient's life history, diagnosis, clinical course in hospital, degree of improvement, and expected family and community environment. Better understanding of relapse factors would greatly aid the development of rehabilitation programs for patients while they are still in the hospital and later when they have returned to the community.

Thus, it is not as if some of the questions that needed to be asked before the deinstitutionalization movement took on momentum were never raised. They were raised; but, in practice, they were not acknowledged. The movement went forward on its own momentum, too often impervious to attempts to steer it onto a course consistent with clinically derived principles and theoretically derived expectations.
IV. A FUNCTIONALIST PERSPECTIVE

"Because of the interdependence of the components of society, change at any one point is likely to precipitate changes elsewhere. These changes may come unheralded, unpredicted, and frequently from the viewpoint of many groups, unwanted."

—Ely Chinoy, 1954

The functionalist approach in the behavioral sciences consists of a series of basic concepts which are interrelated within a theoretical framework fundamentally oriented toward the understanding of social change. In the present section of this study, some of these concepts will be explained and will then be applied to the issues described in the previous section. The importance of social change within the functionalist framework will then be emphasized as the basis for further examination of deinstitutionalization issues.

BASIC CONCEPTS IN THE FUNCTIONALIST APPROACH

The central concept in functional analysis is the function, which is defined in terms of contributions to the "fulfillment of one or more social needs of a social system or subsystem" (Johnson 1960, p. 69). In brief, each form or element of a social system—whether a cultural item, pattern, status, norm or value—is identifiable in terms of the functions it serves for society, or, in other words, in terms of the social needs which it fulfills. Note that a function is to be differentiated from a purpose, and that this distinction is an important one. Although the two may be, and often in particular instances are, identical, a purpose is to be regarded as something subjective, a charge; a function is to be regarded, by contrast, as an objective phenomenon. In very simplified terms, a purpose is that which a social form is intended to do, and a function is that which a social form actually does. To illustrate, the purpose of opening a crisis center may be to provide ready intervention in emergency situations; the functions of the crisis center may include, in addition to this purpose, other functions, such as providing employment for telephone operators and providing outlets for community service organizations. In fact, these latter functions may persist in keeping the crisis center open even if the original purpose of emergency intervention is no longer being fulfilled.

Functions are to be understood as positive phenomena, in that they fulfill societal goals or objectives and thus contribute to the survival of society's institutions. Sometimes, social forms are, however, negative in consequence and actually inhibit the realization of societal goals. In such cases, the social forms are said to be dysfunctional. The distinction between function and dysfunction is described in this way by Merton (1957, p. 51):

"Functions are those observed consequences which make for the adaptation or adjustment of a given system; and dysfunctions, those observed consequences which lessen the adaptation or adjustment of the system." Thus, for example, operators' personal use of crisis center telephone lines to the extent of interference with the receipt of emergency calls becomes a dysfunctional element in the enterprise. A given social form may be both functional and dysfunctional, depending on the point of view of particular social subsystems. In our simplified example, the telephone operators may realize fulfillment of personal goals, while the organizational goals of the center are being inhibited by the influx of non-business calls.

Functions may also be characterized according to whether they are manifest or latent. Manifest functions are, in general, those that are "intended and recognized by the participants in the system" (Merton 1957, p. 51). Contrariwise, latent functions are unintended, and, for purposes of the present study,
may be understood as unanticipated consequences
given social forms. Latent functions are not necessarily dysfunctional, although they may be. The illustration of the inaccessible telephone lines is clearly both unanticipated and dysfunctional. On the other hand, the provision of employment opportunities for telephone operators, while a latent function, is positive and hence not dysfunctional. The importance of the distinction between manifest and latent functions is explained by Chio-
noy (1954, pp. 39-40):

It is essential in examining the functions of social institutions to distinguish between the purposes or reasons which are conventionally given for their existence and the objective consequences which flow from them. Purpose and result need not and in most cases probably do not completely coincide. A distinction therefore must be made between manifest and latent functions.

An additional concept in the functionalist approach is that of the functional alternative. This is explained by Merton (1957, pp. 33-34):

... just as the same item may have multiple functions, so may the same function be diversely fulfilled by alternative items. Functional needs are here taken to be permissive, rather than determinant, of specific social structures. Or, in other words, there is a range of variation in the structures which fulfill the functions in question.

It now becomes increasingly clear, in the context of the functionalist perspective, that the deinstitutionalization movement in the United States represents a search for functional alternatives to the mental hospital.

APPLICATION OF CONCEPTS: THE FUNCTIONS OF ASYLUM AND CUSTODY

This characterization of the deinstitutionalization movement as a quest for functional alternatives demands that the functions—manifest and latent—of the mental hospital be made explicit. An attempt to do so, at least partially, was made in a largely overlooked article by a psychiatrist, Robert M. Edwalds, over a decade ago (1964). Edwalds held that “the primary social functions of the state mental hospital are not the same as the publicly proclaimed purposes and goals of these institutions.” He wrote:

Primary functions demanded of the state mental hospital have included (A) public safety and the removal from society of individuals exhibiting certain kinds of socially disruptive behavior; (B) custodial care for persons who, by reason of mental disorder, cannot care for themselves or be cared for elsewhere. Treatment and rehabilitation of the mentally ill has always been, at best, a secondary function of the state mental hospital. For many years it was not considered part of the function of the state hospital at all. Today treatment and rehabilitation are usually officially regarded as the primary functions of the state mental hospital, leading to a remarkable amount of self-deception and confusion on the part of society and the personnel working in these hospitals.

Edwalds saw the very use of the term hospital to refer to these mental institutions as misleading and productive of naive misunderstanding of the “true” functions.

What Edwalds was saying, translated into functionalist terms, is that, although the stated goal of the mental hospital may be treatment and rehabilitation of the mentally ill, this is at best only a limited function. Instead, the major functions of the mental hospital are, in reality, custodial in nature. These custodial functions of mental institutions are grounded in the social history of this Nation (Dain 1971; Jarcho 1976; Rutman 1976).

The importance of Edwalds’ position cannot be overemphasized! If his characterization is accurate, a giant step toward understanding the issues inherent in deinstitutionalization was taken over 10 years ago, when the movement was young. To the extent that Edwalds’ theory has validity, it may be hypothesized that many of the problems confronting the deinstitutionalization movement result from the failure to provide functional alternatives for some of the basic functions served by the mental hospital. The logical conclusion that follows from a functionalist point of view is that mental hospitals must not, and cannot be eliminated until alternatives for the functions of asylum and custodial care have been provided.

The early literature on deinstitutionalization, which reflects the mood underlying program planning in the 1960’s, largely ignored or discounted these custodial functions of mental hospitals. Instead, the focus was on providing treatment (not custodial care or asylum) in the community. But, as it turns out, Edwalds was prophetic. His name is, for the most part, absent from bibliographies and literature reviews. Yet, recognition of the

* A notable exception is Dingman (1974), who utilizes the Edwalds article as the basis for much of a cogent argument favoring the retention and meaningful modification of the State hospital.
functions of asylum and custody has become more and more prevalent in the literature of the mid-1970's. Thus, Slovenko and Luby (1974) write:

The medical model terminology has been misleading. When we use the term "hospital," we naturally think of treatment. Hospitalization without treatment is an absurdity... If, however, we understand by the term "hospitalization" nothing more nor less than asylum (as the mental hospital at one time was called), a place of refuge, there is no connotation of medical treatment but rather one of treatment in the broad sense as meaning "handling of" or "how we treat one another." 24

Fowlkes' article, entitled "Business as Usual—at the State Mental Hospital," (1975)—one of four recent articles cited earlier as contributing substantially to elucidating the issues in deinstitutionalization—is entirely devoted to an examination of those forces which serve to resist innovations at State mental hospitals and thus to preserve them as custodial institutions. Fowlkes, in effect, perceives a kind of conflict of interest in which institutionalized (in the sociological sense) aspects of the mental hospital are functional for some societal groups (hospital administrators and staff, patients' families, vested economic interests, etc.), but dysfunctional for others (patients). If corroboration from modern experts is to be regarded as a measure of the validity of Edwards' theory, one can only conclude that he was indeed on the right track at the wrong time.

APPLICATION OF CONCEPTS:
ADDITIONAL FUNCTIONS

An attempt to isolate some of the functions of mental hospitals as identified in the literature yields the following listing:

- Providing long-term care for chronically disturbed individuals (Dingman 1974; Stewart 1975)
- Providing respite from mounting pressures for the patient (Dingman 1974; Stewart 1975)
- Removing the patient from "his usual inter-

24 Selected additional references expressing the need to recognize the functions of asylum and custody at mental hospitals include: Bewley et al. (1975); Clausen and Huffine (1975); Chu and Trotter (1974); Cumming (1974); Dingman (1974); Finzen (1974); Lieberman and Gardner (1976); Rosenblatt (1974); Rosenblatt (1975); Rutman (1970); Saper (1975); Stone (1975a); Sotsky (1968).

personal environment which may operate to perpetuate sick behavior" (Lewis 1973)
- Protecting the patient from "undue pressure" or exploitation by others (Dingman 1974)
- Providing a residential environment for the mentally ill (Fowlkes 1975)
- Providing constant and continuous monitoring and review of the patient's course of illness (Lewis 1973)
- Providing a social structure within which the role of the mentally ill individual is clearly defined (Rosenhan 1973; Sanders 1974)
- Providing the mentally ill individual with an alternative to due process of law (Polak and Jones 1973)
- Providing a place for escape for the patient from the society in which his behavior is "friction producing" (Polak and Jones 1973)
- Providing the means by which society can segregate its deviants (Polak and Jones 1973)
- Relieving the patient's family and community from disruptive social interaction (Fowlkes 1975; Aviram and Segal 1973; Doll 1976; Doll, Thompson, and Lefton 1976); "absorbing the strains of sickness" (Susser 1964)
- Protecting society from the acts of dangerous individuals (Dingman 1974; Hanson and Babigian 1974)
- Supplying the least expensive patient care for the mentally ill "on a short-run, annual budget basis" (Fowlkes 1975)
- Providing the economic base of and employment for a community or a portion of a community (Fowlkes 1975; Dingman 1974; Weiner and Bird 1973; Keenan 1974; Schulberg, Becker, and McGrath 1976)
- Providing job security and other job perquisites for numbers of employed persons (Fowlkes 1975; Ishiyama 1974; Weiner and Bird 1973; Schultz, Lyons, and Nothnagel 1975; Dingman 1974; Keenan 1974)
- Providing a tax base for local communities (Schapire 1974)
- Providing for mental health professionals in the community a "siphon[ing] off[of] the least affluent and least attractive of the mentally disturbed, whom they would prefer not to serve anyway" (Fowlkes 1975)
- Creating an "illusion that all local mental health needs are being met, thus eliminating f
the need for... local planning and spending for mental health care" (Fowlkes 1975)

- Providing a place for research on mental illness and training of mental health professionals (Dingman 1974; Stewart 1975)

This listing is limited to those functions of mental hospitals explicitly stated as such in the literature. Were it to be expanded by the inclusion of such functions as are also implicit in the literature, it would be even longer. But, even as it stands, it is sufficient to support an important observation. The issues in deinstitutionalization raised in the last section of this study fall into two major groupings vis-à-vis mental hospital functions. Either: (1) the issue has at least one referent among the functions listed, or (2) the issue has come into being as an unanticipated consequence—i.e., a latent function—of the deinstitutionalization movement. With respect to the former grouping, it is apparent that efforts to reduce the stature of, or eliminate, mental hospitals have too often failed to stress the necessity for alternatives to the custodial and other functions of mental hospitals. It is inevitable that any movement which so ignores the institutional makeup of society will encounter severe opposition.

With respect to the latter grouping of issues—those which emerge as products of the movement itself—it is apparent that the deinstitutionalization effort in process has not been viewed by its champions with sufficient detachment to permit program planners to recognize problems and introduce necessary modifications. Deinstitutionalization has left in its wake dysfunctional elements which result directly from rapid, and sometimes heedless, implementation of the movement.

In short, the ideological basis for deinstitutionalization is one which encourages rapid social change in an institution (in the sociological sense) which is woven into the fabric of American life. The semanticist, Hayakawa (1949, p. 276), explains the conservatism which such a threat engenders in his statement that "social institutions tend to change slowly—and, most importantly—they tend to continue to exist long after the necessity for their continued existence has disappeared, and sometimes even when their continued existence becomes a nuisance and a danger."

Part of the reaction against deinstitutionalization has resulted from society's resistance to what Coser (1975) calls the "threat of territorial invasion." Coser's argument (which deals with social change in other areas of American life) holds that geographical displacement typically constitutes enough of a threat to the existing social order to mobilize conservative antichange forces. Unless geographical displacement is "patterned in such a way that it will not interfere with the existing pattern of role relationships," it can become an intolerable threat to society. The role-blurring issue in deinstitutionalization provides evidence that geographical displacement in this instance has in fact interfered with role relationships and that part of the resistance to the movement may be understood in this way.

To recapitulate, the absence of acceptable functional alternatives for the functions served by mental hospitals, coupled with attempts to displace the territorial and other claims of the institutionalized system of mental health care—all occurring with great speed—have produced serious problems in implementing the goals of the deinstitutionalization movement.

A final word remains to be said regarding the functionalist approach. If there are gaps in the interpretation of deinstitutionalization that it affords, that is no surprise. It is not the intent of this study to suggest that the functionalist approach is the legitimate avenue to understanding deinstitutionalization. It is simply an approach, one which permits systematic ordering of the data, impressions, and judgments about deinstitutionalization that are found in the literature. Other theoretical frameworks will also be useful to this end, to the extent that they help to make sense of the elements in the process of deinstitutionalization and to unify seemingly discrete bits of material. In fact, other approaches should be viewed as potentially complementary to the functionalist perspective—as helping to enhance the understanding of elements that still appear to be at loose ends.
V. DISCUSSION

"Nowhere is the discrepancy between public and private morality, between verbal pronouncements and actual behavior, more apparent than in the field of psychiatric aftercare. The literature is replete with descriptions of demonstration projects, state-wide programs, bold innovations, and triumphs of interagency collaboration. Yet, an objective observer can quickly conclude, if he reviews the typical post-hospital experience of psychiatric patients, that aftercare services in reality do not exist for the vast majority of persons leaving state and local mental hospitals."

—H. G. Whittington, 1969

Has deinstitutionalization really, thus far, resulted in the exchange of one set of ills for another? Have the dysfunctional elements of institutional care merely been transferred to the community, so that, in the words of Slovenko and Luby (1975), "mental patients are going from the frying pan into the fire" and that "neglect in the community dwarfs neglect in hospitals"? If one proceeds from the assumption that the basic goal of the deinstitutionalization movement is the elimination of dehumanization in the treatment of the mentally ill, one must acknowledge that, on the basis of the existing literature, community-based programs have not been immune to dehumanizing forces. While the position taken by Slovenko and Luby may be an exaggerated or polarized statement, it does now seem clear that the deinstitutionalization movement has not had unqualified success in its humanizing mission. Like other movements of social reform, it has produced a series of largely unanticipated consequences (latent functions) of a dysfunctional nature; like other efforts at institutional change, it has brought into play the forces of resistance which have themselves at times been dysfunctional.

But this by no means necessarily indicates that the movement is a failure. It does, instead, mean that the time has come to face the issues squarely, so that the movement can achieve its promise. For example, it may now be understood—and potentially acted upon—that the issue of selecting patients for community care is closely related to the functional confusion described by Edwalds. Selection of a patient population or target group follows from an agency's understanding of its raison d'être. But if it is unclear what functions are to be transferred from the mental hospital to the community, it must also be unclear which patients should be served in the process. The deinstitutionalization movement may eschew the functions of

* Orndoff (1975, p. 222) adopts this assumption emphatically: "Institutionalization is a dehumanizing process where the patient's individuality is lost, his self-concept greatly lowered, and in many cases, his ability to make even the simplest life decisions seriously impaired. With this in mind, the goal of any community residential program must be to reverse the process."
custody and asylum; but it must still acknowledge that these have been functions of the mental hospital, the need for which will not simply disappear with the dismantling of custodial facilities. With this recognition can come modified planning and action.

A major shortcoming of the deinstitutionalization movement, one which has clouded the issues and confounded investigative efforts, has been the tendency of persons connected with selected community programs to reason inductively that the entire movement is “working,” when obviously this is not always the case, thus deflecting attention from the issues which must be resolved. A number of experimental community treatment models which report success are described in the literature, and some of these are exceedingly innovative. However, persons encouraging the diffusion of specific treatment models frequently fail to comprehend the dimensions of the deinstitutionalization problem and the fact that their programs care for only a small portion of deinstitutionalized individuals. They frequently, in addition, fail to take into account that: (1) the resources—both personnel and financial—of their own communities may not be available to other communities; and (2) their specific programs may not be compatible with the culture bases in other communities. Too often, these programs preselect patients to fit in with criteria set by experimental design, and their supporters sometimes forget that these selected patients are not representative of all mentally ill people.

There have certainly been commendable community programs, and the importance of these is not to be minimized either in humane or experimental terms. But, at the present time, such isolated programs can only be perceived as band-aids. We must not delude ourselves into thinking that any one or a combination of such programs provides comprehensive answers to the massive problems of the deinstitutionalization movement. Although proponents of specific localized problems may be certain that one or another selected approach is “the answer,” on a more general level it may well be asked, “What is the question?” In functionalist terms the question becomes one of identifying the appropriate functions of mental hospitals and the providing of functional alternatives in the community on a widespread—not just local—basis.
VI. CONCLUSIONS

"That reform movements often create more problems than they solve has been noted, and the task of each succeeding generation is to correct the excesses of the last... There comes a time when reformist zeal must be matched against available data, and while the humanistic goals may persist the paths to them must be modified. This clearly is overdue for the field of mental health."

—Franklyn N. Arnhold, 1975

"Fundamentally, the need that must be faced is the establishment of programs to meet the needs of people whether they are in institutions or in the community."

—Ralph Slovenko and Elliot D. Luby, 1975

The basic conclusions of this study are simple, and, it seems, inescapable. The deinstitutionalization movement—a movement intended to counteract the effects of dehumanization in mental health care—can best fulfill its promise if certain conditions are met. Individual mental hospitals are most effectively superseded, in accord with the aims of the deinstitutionalization movement, when: (1) there is a thorough understanding of the functions which they serve in American life; (2) consensus is reached as to which of these functions should be continued or discontinued, or which new functions should be added; (3) effective alternatives are established in community settings for the accepted functions; and (4) sufficient time is allowed for the systematic and orderly implementation of new programs and transfer of functions.

In one important respect the deinstitutionalization movement has come a long way. The era of polarization seems to be passing, and, finally, the voices of moderation are being heard. This sets the stage for more realistic planning. However, there still remain some very serious problems with which to contend. Although it is increasingly recognized that there must be a range of treatment alternatives including a variety of hospital- and community-based choices, there is little in the way of consensus regarding what kinds of service facilities can best fulfill what kinds of functions. Some choices must be made. Mental health service delivery agencies, particularly those which might appear to be less traditional and more innovative, have what Franklin and Kitredge (1975) call serious problems of legitimacy and boundaries. Legitimacy involves the "defining of a domain, a set of tasks or activities over which the organization claims jurisdiction." Whereas organizations whose services can easily be measured by accepted objective criteria have relatively less difficulty in establishing boundaries, it is extremely difficult to define boundaries for what these writers call "people-changing organizations." One reason is that there is considerable overlap in the jurisdictional claims among such agencies. The "boundary busting" nature of community mental health—its tendency to blur the boundaries of other agencies—is the subject of timely and thought-provoking discussions by Dinitz and Beran (1971) and Wagenfeld (1972).

If the deinstitutionalization movement is to proceed more effectively, it would seem that a first step to take is to define precisely, in the light of accumulated experience, what are the target groups for the movement. Precisely which patients are to be deinstitutionalized? What patients do we mean when we talk about providing community care? Do we mean all persons in mental hospitals, or do we mean only those, who by virtue of specific demographic or diagnostic characteristics they possess, may be assigned to some localized experimental..."
program? Do we mean patients who are hospitalized primarily for lack of other places to go—i.e., inappropriate hospitalizations? Or do we mean only those patients who might be considered “good risks” for rehabilitation via the community route?

Le's this study appear to place undue emphasis on the negative aspects of deinstitutionalization, let it be made clear that the aim of this work is supportive in nature. In fact, this study may be regarded as an endorsement of the major goal of deinstitutionalization. Were this not the case, there would be no need for such a study. Focusing on dysfunctional elements of the movement is not an indictment but rather a necessary step in bringing to the surface those factors which have inhibited the movement’s success. The final conclusion, of course, is that the deinstitutionalization movement can best proceed on its humanizing mission if it avoids territorial arguments: it is not necessary, and probably not desirable at this time, to expunge the mental hospital in order to achieve the goal of deinstitutionalization. It is certainly unwise to attempt to do so in haste. Community planners need to understand that hospitalization “does not, as some have suggested, signify the failure of alternative methods of care” (Adams 1975). There is a need to re-assess the functions which are known to be served by mental hospitals and to determine, without prejudice, those which are not likely to be fulfilled in community settings.

Mental hospitals that survive the deinstitutionalization movement can themselves aid in the humanizing effort. These hospitals will have the potential for elevating patient treatment to a primary function; the functions of asylum and custodiy do not preclude this. In addition to the brief hospitalization trend cited earlier, which can be implemented in mental hospital settings, other innovative programs can be encouraged. Day care, or partial care, which “apparently avoids the regressive features associated with ‘total institutionalization’” (Herz et al. 1971) is one such kind of program. Hospital-based outpatient care and outreach programs are others (Stubblefield 1976a).

--The literature contains a number of studies dealing with inappropriate placement of patients in mental hospitals. Selected references include: Arthur Bolton Associates (1974); Arthur Bolton Associates (1975); Lund (1976); Sheehan and Craft (1975); Foutrell and Majumder (1975); Washburn, Vannicelli and Scheff (1975).

--Also see: LaCommare (1975); Lamb (1976); McNabola (1976); Michaux et al. (1973b).

Texas DMHMR 1976). The siting of such programs at mental hospitals can in fact aid in overcoming the issue of fragmented care, especially if transportation for patients is facilitated. Along these lines, Johnson et al. (1975) advocate the “mini-mental health center,” a program which provides both inpatient and outpatient care on a single hospital ward, thus allowing for comprehensive treatment by the same treatment team. These authors point out that the traditional mental health center can provide continual care, but their program has a capability for real continuity of care, which is not the same thing.

Still other steps can be taken to make the movement more responsive to the needs of patients. Certainly one area where change is essential is in the setting and monitoring of standards for residential facilities. It is important to remember, in the words of Crane (1974), that “hospital substitutes,” like halfway houses, day care centers, and nursing homes, can cope with a limited number of patients. The quality of their services can only deteriorate when the demand becomes excessive.” Care must be taken to assure that such facilities are not overloaded or oversold.

Another avenue for the enhancement of the goals of deinstitutionalization is the local screening of patients before their admission to mental hospitals. Screening programs can assist in the determination of which individuals definitely require custodial care and which can best be treated outside of institutions (Feldman 1974); Processes of partial or total withdrawal, screening can also assist in determining whether there exist patients for whom community-based care is not the treatment of choice and for whom hospitalization might really be the desired alternative. Finally, in addition to preadmission screening for assignment or reassignment to mental hospitals, there should be screening for the variety of care-giving agencies within the community as well. The screening program should thus take responsibility for assignment of patients to residential facilities as well as treatment services.

--Also see: Fox and Potter (1973); Hutt (1971).

--A variety of references deal with the place of halfway houses and other residential facilities in the deinstitutionalization movement. Selected references include: Atkinson (1976); Atkinson (1975); Cannon (1976a); Cannon (1976b); Edelson (1976); Horizon House Institute (1974); Levin (1976a); Orndoff (1975); Orton and Wilkin (1975).
Just as pre-admission screening may serve to minimize dehumanization, so should an effort be made to enhance the role of pre-release planning at mental hospitals. Many patients must be trained for life on the outside, and this represents a major opportunity for innovativeness and originality in the hospital setting. Pre-release planning must include, at a minimum, an effective referral mechanism. Zolik, Lantz, and Sommers (1969) have shown that patients released without referral are more frequently and more readily rehospitalized than those who have been given referrals. Pre-release planning must also include plans for the followup of patients in the community. Such plans must be prospective and must precede the patient’s release. It is simply too difficult to track a patient retrospectively. Liaison personnel, who work between hospital and community-based facilities, are essential for followup.

It is important that the territoriality exhibited by competing community-based treatment and service agencies be neutralized by cooperative effort. It is possible to develop community-wide mental health plans which endeavor to implement the aims of competing organizations and to express the consensus of all participating units (Bachrach 1974). Such cooperative planning is to be strongly encouraged: it provides specific agencies with the knowledge that their views count and their contributions are valued. J. Howard (1975) provides a theoretical framework which may be used to view the segmentation of community services in mental health. She presents four models of interaction between professionals and patients. In the 1:1 model a single professional provider relates to a single consumer. The 1:n model typifies one provider relating to more than one consumer, the n:1 model depicts a relationship between more than one provider and one consumer, and the n:n model contains both multiple providers and multiple consumers. Fragmentation, which is absent from the 1:1 model, is most pronounced in the n:n model. Deinstitutionalization has frequently resulted in a variety of service relationships with multiple producers and/or consumers and especially those of the n:n type. While this is not an "inherently depersonalizing" service model, Howard does suggest that it may present the most obstacles to humanized care.

Finally, not enough can be said about the importance of improved information systems in implementing the goal of the deinstitutionalization movement. It is essential that we know who is being treated where, with what success, and for what reasons. Unless a mental health plan can check itself and modify itself in process, its efforts run a huge risk of veering off-course and producing dysfunctional patterns which become increasingly difficult to reverse. The only way to assure that specific programs connected with deinstitutionalization efforts do not autonomously take on questionable latent functions is by effective monitoring and continuing assessment of their relevance through process and outcome evaluation. We can only know whether community mental health care "works" if we have the data to substantiate our premises. A quotation by Martins (1975) is apposite:

The basic function of planning and the research activities that take place as part of the planning process is to improve the quality of decisions made over time. The most striking characteristic of many planning systems is their failure to impact on the decision making process. While planning in a vacuum often produces documents that are impressive from the point of view of technical craftsmanship, such planning rarely impacts on decisions. Planning’s reason for existence is to improve the quality of decisions.

It would appear that major hurdles have been negotiated and that it is possible to be optimistic about the future of the deinstitutionalization movement. The movement has passed through an infancy, a childhood, and a rebellious adolescence. It is now ready to embark on a mature quest for answers to the issues which have plagued it.
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A Model for Deinstitutionalization

**ABSTRACT.** One of the most critical concepts affecting the lives and services for the retarded today involves deinstitutionalization. This paper explores some of the problems associated with this process and considers five aspects deemed important to a successful effort.

**R. C. Scheerenberger**

**On February 5, 1963, President John F. Kennedy concluded his message to the Congress of the United States with the following challenge:**

We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower.

This tradition of neglect must be replaced by forceful and far-reaching programs carried out at all levels of government, by private individuals and by State and local agencies in every part of the Union.

We must act—

to bestow the full benefits of our society on those who suffer from mental disabilities;

to prevent the occurrence of mental illness and mental retardation wherever and whenever possible;

to provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders;

to stimulate improvements in the level of care given the mentally disabled in our State and private institutions, and to reorient those programs to a community-centered approach;

to reduce, over a number of years, and by hundreds of thousands, the persons confined to these institutions;

to retain in and return to the community the mentally ill and mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services; and

to reinforce the will and capacity of our communities to meet these problems, in order that the communities, in turn, can reinforce the will and capacity of individuals and individual families.

We must promote—to the best of our ability and by all possible and appropriate means—the mental and physical health of all our citizens. (Kennedy, 1963, pp. 13-14).

Eleven years have elapsed since this statement was issued and various systems, programs, and techniques have been tried. Some have been successful, some have failed. Today, many community and residential services cannot meet acceptable levels or standards of programming. In 1960, there were 160,000 retarded persons in public residential facilities for the mentally retarded and 53,000 in private residential facilities and mental hospitals (President's Panel on Mental Retardation, 1962). By 1969, the number of retarded persons had increased to 190,000 in public residential facilities and 65,000 in private facilities and mental hospitals (Office of Mental Retardation Coordination, 1972). While there has been a major effort over the past several years to reduce residential populations, many persons have been transferred to inappropriate, under-programmed community facilities.

**Deinstitutionalization**

All states are attempting to meet the needs of retarded citizens and, at the same time, resolve some of the critical problems confronting most residential facilities through the dual processes of deinstitutionalization and institutional reform. The primary emphasis of this discussion will be upon deinstitutionalization.

Deinstitutionalization encompasses three interrelated processes: (a) prevention of admission by finding and developing alternative community methods of care and training, (b) return to the community of all residents who have been prepared through programs of habilitation and training to function adequately in appropriate local settings, and (c) establishment and maintenance of a responsive residential environment which protects human and civil rights and which contributes to the expeditious return of the individual to normal community living, whenever possible. In contrast institutional reform involves a modification or improvement in attitudes, philosophies, policies, effective utilization of available resources, and increased financing to provide adequate programs to motivate and assist individuals to reach their maximum level of functioning in the least restrictive environment possible (National Association of Superintendents of Public Residential Facilities for the Mentally retarded, 1974, pp. 4-5).

**The Community**

In order to establish a model from which to proceed, this discussion will emphasize (a) the community, (b) the residential facility, and (c) the mechanics through which each can assume its proper roles and functions. The term "community" can be considered from two points of view: (a) the socio-political community, and (b) the individual's community. Socio-political definitions of a community usually refer to a group of persons with some common background residing within a relatively restricted geographical area:

A community is "a social group of any size whose members reside in a specific locality, share government, and have a common cultural and historical heritage" (Stein and Urdang, 1967, p. 29).

A community is "a general population having a common interest or interdependence in the delivery of services" (NARC Residential Services and Facilities Committee, 1973, p. 75).
The individual's community is concerned with the experiences and mobility that he has within the socio-political community and his interactions with the people, services, and facilities contained within. Normally, the individual's community is smaller than the socio-political community as defined.

The residential facility's community also can be considered within the dual context of a socio-political area and its individual interactions. As shown in Figure 1, the residential facility exists within a socio-political community and may be part of the individual's community if he uses the services available. Although a residential facility may be located within or near a socio-political community, its services may extend to a number of such communities or, in some cases, throughout the state. Finally, communities also exist within the framework of a larger societal structure (county, state, and nation), all of which may influence to some degree each community and its inhabitants.

By definition (and practice) a residential facility must be considered an integral part of any community. The degree to which it is a successful member of that community depends upon the degree of its involvement and interaction.

The community that is available to the retarded should offer the "least restrictive environment;" however, placements in foster homes, group homes, or nursing homes, frequently are more restrictive than residential living in a public facility. For example, Murphy, Penne, and Luchins (1972) studied foster home programs in Canada and concluded:

1. There was very little interaction between residents and family. In fact, one of the authors observed that in most homes there was not merely "a lack of interaction, but a lack of any activity whatever" (p. 5).

2. Segregation and uniformity were common, e.g., certain days were set aside for shaving and others for bathing.

3. In many cases, there was no interaction between residents and other persons or facilities within the community.

Luchins summarized his observations by stating:

... it is my opinion that those who think foster home placement enables a patient to escape the disadvantages of an institutional life are mistaken. Foster homes can be as institutionalized as hospitals are, while lacking the compensatory advantages that some hospitals might possess (p. 14).

Time magazine (1973, p. 74) described deinstitutionalization experiences in California:

... chronically ill patients have been returned to communities poorly equipped to provide adequate treatment. With no one to care for them, former patients have ended up on welfare roles, in boarding houses, cheap hotels, and even jail.

and in New York:

... since New York state started emptying its mental hospitals of the tens of inmates six years ago, many of them have been jammed into tiny rooms, basements, and garages, and fed a semi-starvation diet of rice and chicken necks. ... they are taken from the steps of mental institutions by operators who jam them into what can only be described as a private jail and confiscate their monthly welfare checks.

While it cannot be ascertained whether Time was referring to the mentally retarded as well as to the mentally ill, the circumstances associated with many of the placements of the retarded over the past several years have been similar.

These comments are not made to condemn the idea of community placement for retarded persons. Nor are they intended, in any way, to justify inadequate practices or services in residential facilities. These statements do, however, clearly demonstrate that any program, regardless of the facility or location in which it is being implemented, must be assessed only in terms of individual needs. According to the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974, pp. 2-3):

While the Association advocates without reservation the rights of the retarded to live in the least restrictive environment and to enjoy fully the benefits of a free and open society whenever possible, it does express concern over the manner in which this goal is being realized. First, the quality of community programs and services being offered to the mentally retarded and other developmentally disabled persons in many parts of the country is inadequate. All too often, "community back wards" and "closeting" are being substituted for institutional "warehousing." Neither community nor residential back wards or "closeting" are justified: the rights of the retarded must be respected wherever they reside. In essence, the Association calls attention to the need not only for continued upgrading of residential facilities... but also for a greater interest in quality control for developing community programs.
Roles and Functions

The respective roles and functions of the community and one of its agencies, the residential facility, are outlined in Table 1. No attempt has been made to record all services which should be available. Extensive listings can be found in a number of publications, e.g., President's Panel on Mental Retardation (1962) and the NARC Residential Services and Facilities Committee (1974).

Community services listed have been divided into two categories: those which must be available and those which should be available. Services which must be available include an adequate living environment, health services, training and education if appropriate, some form of employment for older retarded persons, and mobility. The latter is important. The individual not only should be in a position to move freely within the community, but should be trained and encouraged to do so whenever possible, consistent with his needs and desires. Some operators of group and nursing homes are hesitant to permit residents to leave the premises in fear of potential liability suits or negative public reaction in the event of an accident.

Services which should be available include any service offered to the general citizenry. The distinction between what must be and what should be available is important. Occasionally, one will encounter residential staff who believe firmly that a retarded person should not be returned to the community until all desired services are developed. Under such circumstances, few retarded persons would ever leave the residential setting. In essence, one has to weigh the advantages of increased opportunities for independence, freedom, and privacy against those residential programmatic offerings which might be lost by an individual when placed in the community.

If the community is capable of providing primary services and programs required by retarded persons, what will be the future role of a residential facility? It can be summarized in one word—specialization. It is anticipated that most residential facilities will function as regional centers, offering specialized short-term, intensive treatment programs; specialized extended care and developmental training for severely and profoundly retarded, multiply handicapped persons; and specialized back-up and consultancy services. One of the primary functions of the residential facility in the future will be to prevent institutionalization.

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1 The position statements of the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974) include a more comprehensive discussion of the future role of residential facilities.

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TABLE 1

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<th>BASIC COMMUNITY AND RESIDENTIAL SERVICES</th>
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<td><strong>COMMUNITY SERVICES</strong></td>
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<tr>
<td><strong>SERVICES WHICH MUST BE AVAILABLE:</strong></td>
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<tr>
<td>1. Adequate living environment:</td>
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<td>A. Safe home</td>
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<td>B. Social life</td>
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<td>C. Crook home</td>
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<td>2. Health services</td>
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<td><strong>SERVICES WHICH SHOULD BE AVAILABLE:</strong></td>
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<td>1. Recreational</td>
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<tr>
<td>2. Religious</td>
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<td>3. All other services available to any citizen, e.g., commercial, welfare, family counseling, and protective.</td>
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<tr>
<td><strong>RESIDENTIAL SERVICES</strong></td>
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<tr>
<td>1. Specialized diagnosis and evaluation</td>
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<td>2. Specialized short-term training and treatment program</td>
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<td>3. Specialized extended care</td>
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<td>4. Specialized back-up and technical consultancy services</td>
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Successful Deinstitutionalization—Five Integrants

The development of adequate community programs for the retarded, the return of many retarded persons to non-residential settings, and the realization of appropriate roles and functions by both the community and residential facility require five integrants. These are shown in Figure 2.

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![Figure 2: Integrants to Effective Programming](image-url)

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DECEMBER • 1974
1. There must exist on a local or regional level a visible agency or body with statutory authority to plan, implement, and coordinate programs for the retarded. These agencies must be legally accountable for services offered to the retarded in general and each individual in particular. Wisconsin recently passed legislation to create community boards on a county level with the full authority, responsibility, and accountability to provide the 16 services associated with the Federal Developmental Disabilities Act—P.L. 91-517: evaluation, diagnosis, treatment, day programs, training, education, sheltered employment, recreation, personal care, domiciliary care, special living arrangements, counselling, information and referral, follow-up, protective and other sociological services, and transportation. As of January 1, 1974, all state funds, excluding those for public schools and public residential facilities, were channeled through these boards and their professional staffs. There is nothing new about the concept of local boards. Many states have tried similar arrangements, usually with minimal success. The difference is that in Wisconsin the boards have statutory sanction and control over funding. Since their establishment there has been considerable local activity in providing a variety of services to the retarded and other developmentally disabled persons.

2. An independent standard-setting and monitoring agency must be created. This can be accomplished in several ways: by establishing within the state an independent standard-setting group; by assigning such a task to a state agency; or by requiring accreditation through the Accreditation Council for Facilities for the Mentally Retarded. The essential ingredient is the setting of standards and their evaluation reflect only the needs of the retarded. Inadequate programs should be given an opportunity to improve; however, if the required improvements are not evidenced according to a set schedule, funding should be terminated. While local boards would not set standards, they would retain responsibility and accountability to see that such standards were met.

3. Local boards and agencies must have access to quality back-up services, including technical consultancy. Many communities will require the expertise of persons who have had extensive experience in dealing with the mentally retarded. Hopefully, residential staff, university personnel, and representatives from established community agencies will pool their talents in a collaborative effort to provide the retarded with the finest programming possible.

4. All community programs, including residential, must receive substantial financial support. Neither the community nor its residential facility can provide for the retarded unless it has access to an adequate resource of funding for programming, training, and research. Quality services are costly, regardless of where they are offered.

5. There must exist a tough-minded, strong-willed advocacy program. Three systems have been proposed: (1) legal, (2) agency, and (3) citizen. A system of legal advocacy emphasizes the rights of retarded persons and relies primarily on legally trained advocates. The agency advocacy approach, in contrast, vests broad protectorship in a state department or agency. Protectors, who usually are behaviorally trained professionals, have responsibility to "provide guidance, service and encouragement in the development of maximum self-reliance to a mentally retarded or other developmentally disabled person, independent of any determination of incompetency" (Ohio ... 1972, p. 7). Citizen advocacy, according to Wolfensberger (1972, p. 12), is defined as "a mature, competent citizen volunteer representing, as if they were his own, the interest of another citizen who is impaired in his instrumental competency, or who has major expressive needs which are unmet and which are likely to remain unmet without special intervention."

Of these three systems, all of which have distinct value, the legal approach is most critical at this time. The retarded should share the same advantages and responsibilities as any other citizen in our society; in other words, their rights must be recognized. The question of individual rights is a legal matter which can best be represented by professionals of that discipline. As stated by Gilboil (1973, p. 53):

The language has changed. It is no longer the language of favor or benefit. It is no longer the fact that what comes to the retarded child and his family comes out of the good will and the graciousness of others. It is now the language of rights. What comes, comes as a right. It is really not the language of love and kindness but of justice.

When the rights of the retarded have been clearly enunciated and understood by all, then, they can be represented more effectively by parents and other advocates with various experiential backgrounds. Until that time, the legal advocacy system should receive priority.

Reform

Deinstitutionalization is both desirable and feasible. A successful program of deinstitutionalization, however, will require institutional reform, community reform, and judicial reform, and legislative reform. Each residential facility must reexamine its philosophy and services to insure that every resident is receiving a total development program, individually designed, intended to facilitate community return. Further, residential services, including technical consultancy, must be extended to the community at large to assist in developing local programs and averting the need for extended residential placement, whenever possible. The community, in turn, must express a greater willingness to include the retarded in the mainstream of everyday life and make a concerted effort to provide adequate services. The judicial system must recognize and protect the rights of the retarded and respond to existing inequities with alacrity. Legislators, at both state and national levels, also must recognize and protect the rights of retarded and provide those laws and resources necessary to enable them to live as full and rich a life as possible within the total society.
Summary

Deinstitutionalization is a desirable aim for all but a few retarded persons, and it can be attained within a relatively short period of time. The needs and rights of the retarded must be recognized and honored in both the community and residential setting. Although there has been considerable reform among many agencies and professions serving the retarded over the past several years, much remains to be accomplished. We have yet to "bestow the full benefits of our society on those who suffer from mental disabilities."

References


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From LOS ANGELES to LONG ISLAND . . .
Introduction

A management problem faced by the Indiana Department of Mental Health is to determine the population forecast of the state mental hospitals and use this statistic in seeking funds from the Indiana General Assembly. The 1975 General Assembly provided staff increases based upon the Wyatt-Stackney standards and the previously developed 1979 population forecast.

The objective of this study is to forecast the average daily population in the twelve state mental hospitals for FY77 through FY81. This study should be based upon a review of the literature, an analysis of existing data, assumptions that can be identified, and sound forecasting methodology. This forecast will be used by the Department in preparing its budget for the 1977 Indiana General Assembly.

Review of Pertinent Literature

The resident population in state and county mental hospitals (serving primarily the mentally ill) during the ten year period of 1945-55 increased to a high of 558,922 at the end of 1955.1 There has been a continued reduction in the patient census, and the provisional data for Fiscal 1975 is 193,436.2 This is a 10.3 percent drop from the previous year.

The following are some factors that have influenced this decrease in state hospital population.3

These factors, which operate to a greater or lesser extent in every State in the Nation, include: Increased availability and utilization of alternate care facilities for the aged; increased availability and utilization of outpatient and aftercare facilities; gradual reduction in the length of stay of admissions; introduction of community mental health centers; affiliation of community mental health centers with state mental hospitals; introduction of more effective screening procedures to prevent inappropriate admissions; administrative changes such as the introduction of the geographic unit system; and deliberate administrative efforts to
reduce the resident population. These factors are, of course, highly
interrelated and affect the rates of admission, readmission, and dura-
tion of stay which, in turn, generate changes in the resident patient
population.

Great Britain has also experienced a decline in their state hospital
population. McAtee and Zinkle feel that state hospitals should develop
a new role as a center for human services and state hospitals will con-
tinue to be an important part of the mental health delivery system. The
closing of state hospitals and the reduction of patients' census has
caused some feelings that many of these ex-patients are not receiving
proper care.

The population in public institutions serving the mentally retarded
peaked at 193,121 resident patients in 1968 and declined to 185,855 in
1971. A prediction by Wolfensberger suggests that the relative need for
long-term residential placement for the mentally retarded will be reduced.

The Conklin and Taylor report forecasts a reduction in the patient
census in the Indiana State Mental Hospitals. The Indiana State Budget
Agency has forecasted a decline in these hospitals by using an exponent
smoothing method. Charts One, Two, Three and Four show the actual decline
in population. The FY75 "Official" forecast had an error percentage of 1.3%
and this error percentage increased to 2.67% for FY76. (See Charts Five
and Six.) However, it is the investigator's opinion that a three (3) or
four (4) percent error is accurate enough for this type of forecasting.

Assumptions for the Indiana State Mental Hospital Delivery System

1. The General Assembly will not decide to close a state hospital by
1981.

2. There will be sufficient funds appropriated by the Federal, State
and local legislative bodies to construct and operate the planned 32 com-

-2-
munity mental health centers. Monies will be available to operate houses for the mentally ill, day and residential services for the mentally retarded and developmentally disabled, and outpatient and residential services for those persons with addiction problems.

3. A national health insurance program should have an impact in lowering the number of patients served in state mental hospitals. This insurance program with mental health benefits will become law by June, 1978. The full impact of this program will be felt by state hospitals by January, 1980.

4. Mandatory special education in the public schools will reduce the number of emotionally disturbed school age children and adolescents entering the state hospital system. A similar effect will also occur for mentally retarded children and adolescents.

5. There will be a gradual increase in the number of current state hospital patients placed on Family Care status.

6. The incidence and prevalence of mental illness, mental retardation and other developmentally disabilities, alcoholism and drug abuse will continue at the current rate.

7. There will be a constant proportion of the State's population at high risk (the poor and socially disadvantaged, unemployed, and others) which produce state hospital patients at a high rate.

8. There will be increased acceptance of the mentally ill person, the mentally retarded and developmentally handicapped individual, the alcoholic, and the drug abuser in his or her home community when proper treatment and supportive services are available.

9. The mental health service delivery system, both state hospital and community components, will become increasingly more effective, efficient,
and productive which will result in a reduced need for long-term state hospital care and treatment, plus the average length of stay in a state hospital will be reduced.

The investigator should state that there is disagreement among mental health professionals on such assumptions and if there is agreement on an assumption, then there would be differences of opinion on how this assumption would influence the future population of a state hospital.

The Forecast

The review of national and Indiana data, the survey of relevant literature, and the stated assumptions indicate that the number of patients in state hospitals is declining and it is expected that this trend will continue. Four quantitative forecasting methods will be used to better determine the slope of the anticipated decline.

Semi-logarithmic Method

The average daily population for the years FY67 through FY76 were plotted on semi-logarithmic graph paper (Chart Three). The slope was extended to FY81 and the forecasted average daily population are the following: FY77 6,385; FY78 5,838; FY79 5,338; FY80 4,881; and FY81 4,463.

Cohort Survival Method

Chart Seven demonstrates the cohort survival method of demographic forecasting. This method follows a group of patients over time and forecasts how many should survive or remain in the state hospital population. Column #2 of Chart Seven shows the number of patients enrolled by length of stay in the Indiana state hospital system as of June 30, 1971 (FY71). Column #3 shows the June 30, 1976 (FY76) enrollment by length of stay after five years.
The survival ratio is computed by dividing the FY76 enrollment (Column #3) for a five year length of stay by the number in the preceding five year length of stay in FY71 (Column #2). For example, there were 5,075 patients enrolled with a length of stay of 0 under 5 years on June 30, 1971, and after five years, 1,362 of these patients remained in the state hospital system by June 30, 1976. The figure 1,362 divided by 5,075 yields .2684.

There were 19,178 admissions for FY72 through FY76, but only 3,999 of these patients remained in the 0 under 5 years category.

The June 30, 1976 enrollment is multiplied by the survival rate for the next five year length of stay category and when totaled gives the June 30, 1980 forecast of patients enrolled. For example, there were 3,999 patients enrolled in the 0 under 5 years length of stay category on June 30, 1976, and the survival rate for the 5 years under 10 years length of stay is .2684. The forecast is 1,073 patients enrolled on June 30, 1981, with five years but less than ten years of continuous stay in the state hospital system.

There should be approximately 19,500 admissions for this five year time period of FY77 through FY81 (See Chart Eight). The forecasted 19,500 admissions are multiplied by the .2085 survival ratio (0 under 5 years) which produces the 4,066 forecasted patients enrolled for the 0 under 5 years category on June 30, 1981.

The forecasted enrollment for FY81 is 8,418. This is a reduction of 1,913 from the actual FY76 enrollment of 10,331 or a forecasted drop of 383 for each of the remaining five years. (This assumes that the reduction will be constant.) Thus, the forecasted patients enrolled would be the following: FY77 9,950; FY78 9,567; FY79 9,184; FY80 8,801; and FY81 8,418. When one
subtracts a 3,520 constant (See Chart Eight) between patients enrolled and average daily population, the following becomes the forecasted average daily population: FY77 6,430; FY78 6,047; FY79 5,664; FY80 5,281; and FY81 4,898.

**Component Method**

Chart Eight shows the component method which is also from the field of demography. One can forecast the end of the fiscal year enrollment by adding the anticipated admissions and subtracting discharges and deaths from the known enrollment at the start of the fiscal year. (The July 1st patients enrolled is the June 30th enrollment of the preceding fiscal year.) This process can be continued for each fiscal year to be forecasted.

The admissions, discharges, and deaths were forecasted for FY77 through FY81. The June 30, 1976 patients enrolled (an actual figure) becomes the July 1, 1976 enrollment. The anticipated 3,900 admissions were added to the 10,331 enrollment and the 284 projected deaths and 4,250 projected discharges results in the 9,697 forecasted June 30, 1977 enrollment. The 9,697 figure becomes the July 1, 1977 enrollment and this process continues.

The forecasted patients enrolled would be the following: FY77 9,697; FY78 9,097; FY79 8,527; FY80 7,984; and FY81 7,464. When one subtracts the 3,520 constant between patients enrolled and average daily population the following becomes the average daily population: FY77 6,177; FY78 5,577; FY79 5,007; FY80 4,467; and FY81 3,944.

**Multi-Regression Method**

The multi-regression statistical technique is used in business forecasting and is shown in Chart Nine. The dependent variable in this situation
is the average daily population. The independent variables are believed to cause the average daily population. The investigator developed different independent variables for those state hospitals primarily serving the mentally ill and those serving the mentally retarded and developmentally disabled. It was felt that such a division would produce a more accurate forecast than dealing with the system as a whole. There has been a different pattern of decline between those hospitals serving the mentally ill and those serving the mentally retarded and other developmentally disabled. (See Chart 42.)

The forecasted mentally retarded and other developmentally disabled (MR/DD) clients enrolled in state aided community programs and family care patients were developed with the program specialists in the Department responsible for such activities. Estimated data for outpatient terminations was used for FY75 and FY76 because a new data system was developed during FY75 and it appears the FY75 and FY76 data are not comparable with the previous information. The forecasted outpatient terminations were developed by the investigator based upon the actual and estimated time services data, plus knowledge of the development of the mental health centers. The multi-regression approach produced the following forecast: FY77 6,077; FY78 5,483; FY79 4,891; FY80 4,321; and FY81 3,751.

**Results of Forecasting Methods**

The following are the results of the four quantitative forecasting methods and the "Official" forecast. (See also Chart Ten.)
Average Daily Population (ADP)

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The results of the quantitative methods were taken into account in the preparation of the qualitative or "Official" forecast. It was felt that the decline experienced since FY68 will begin to plateau by FY81. Perhaps this judgement reflects the "art" in the forecasting process and the perceived dynamics of the Indiana mental health system.

**Summary**

There is a management need to develop an accurate population forecast of the Indiana State Mental Hospitals. Such a forecast would help reduce the uncertainty of the future average daily populations which is a key statistic to develop a budget for the Department. The available national and Indiana data shows a decline in state hospital populations. The identified assumptions and review of the literature leads the investigator to believe the decline to continue. Four quantitative methods were presented that assisted in the development of an "Official" or qualitative forecast.

The forecast is the first step in a forecasting, planning, implementation, and evaluation cycle. The anticipated impact of this forecast on the Department should be prepared. A forecast should be constantly monitored. The decisions made within the Department and by other agencies,
legislative bodies, and elected officials should be examined to see if they will influence the population of the state hospitals. One should examine this "what will happen" forecast and decide if the forecast is really "what should happen." A decision that an alternate future should be selected would lead to new planning, implementation, and evaluation activities that will change the forecast.

Both quantitative and qualitative forecasting methods are needed to make forecasts of state hospital populations which are used in the budget process.
Footnotes

The investigator is accountable for the logic and data errors in this paper, however, forecasting is a team effort within the Indiana Department of Mental Health and the whole staff roster could be listed as significantly helpful in the development of the forecast. Special recognition needs to be given to "Ike" Page, Ray Hedges, Marie Hisle, Sue Harris, Kathy Rouse, Phyllis Kern, and Russ Lingenfelter of the Statistics Office. Pamela Pope and Cynthia Brown provided invaluable secretarial assistance. Drs. Kaikomara P. Anklesaria and John T. Liell of the School of Public and Environmental Affairs, IUPUI, provided special counsel. Dr. Martin W. Meyer, Assistant Commissioner for Planning and Evaluation, provided his usual encouragement for professional development of his staff.


2Nessa G. Meyer, "Provisional Patient Movement and Administrative Data State and County Mental Hospital Inpatient Psychiatric Services July 1, 1974 - June 30, 1975," Statistical Note 132, Division of Biometry and Epidemiology, National Institute of Mental Health, July, 1976, page one.

3op.cit., page one and two.


5Ott B. McAtee and George A. Zinkle, "The Evolution of a State Hospital into a Human-Services Center," Hospital and Community Psychiatry, 25, June, 1974, pp.


-10-


BIBLIOGRAPHY


## DEATH RATE PER 1,000 POPULATION OF SELECTED INDIANA STATE MENTAL HOSPITALS, FY67 TO FY76

### Fiscal Years Ending June 30

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### TOTAL DEATHS

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### Sources of Data
FORECASTING THE NUMBER OF PATIENTS
IN INDIANA STATE MENTAL HOSPITALS BY 1981*

By

Donald B. Beeler, M.S.inEd.**


** Director of Planning, Division of Planning and Evaluation, Indiana Department of Mental Health, Five Indiana Square, Indianapolis, Indiana 46204.
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**Total: 1,100 Population (In thousands)**

**Hospital Fiscal Years 1987-1996**

Indiana State Hospital

**November 2006**
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**TOTAL RECEIVABLES**
- 60 ELECTC
- 99 Expanded
- 50 Hospital
- 46 Hemodialysis
- 44 High Volume
- 40 Other

**Preliminary Report Ending June 30**

**Fiscal Years 1996-1997**
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**HOSPITALS IN INDIA**

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Fiscal Years 1972-1986
Indiana State Mental Hospitals

Estimated Breaches, 1976
Indiana Department of Mental Health
## Indiana State Mental Hospitals

### Patients Enrolled

#### Fiscal Years Ending June 30

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### Indiana Population (in thousands)

- 1967: 4,933.0
- 1968: 5,049.0
- 1970: 5,105.7
- 1971: 5,193.7
- 1972: 5,193.7
- 1973: 5,291.0
- 1974: 5,316.0
- 1975: 5,311.0

### Patients Enrolled per 1,000 Population

- 1967: 3.72
- 1968: 3.50
- 1970: 3.27
- 1971: 3.05
- 1972: 2.85
- 1973: 2.63
- 1974: 2.43
- 1975: 2.22
- 1976: 2.09

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| Rate | 70 | 70 | 69 | 71 | 71 | 70 | 71 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 |


For 1982-1986, Indian population: Indian Health Service, Health Resources Administration.
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**Fiscal Years 1976-1979**

*Indian State Mental Hospitals*

*Indian State Mental Hospitals*

Reported Data as of 1976
MEMORANDUM:

TO: Martin W. Meyer, Ed.D.
Assistant Commissioner for Planning and Evaluation

FROM: 

SUBJECT: Patient Movement Data Fiscal Year 1967 - Fiscal Year 1976

DATE: March 1, 1977

Attached are patient movement data including admissions, discharges, patients enrolled, patients present, and deaths for the State Hospital System. Also included are discharge rates per 1,000 population of this data for the six district hospitals.

Attachment
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Total: 779

For selected Indiana acute general hospitals for FY 77 and FY 78.
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Indiana State Hospital for Fry77 and Fry76
Comparison of Admission Lease Termination by Age for Selected Cases
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<th>Difference</th>
<th>Evansville FY67</th>
<th>Evansville FY76</th>
<th>Difference</th>
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<p>| Total Patients Enrolled | 2030 | 1075 | 955 | 2693 | 795 | 1698 | 1200 | 821 | 379 | 2415 | 1637 | 778 | 1853 | 1183 | 670 | 1849 | 868 | 981 |
| Date | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 2-1951 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 6-1951 | 76 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 7-1951 | 60 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 11-1951 | 13 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 11-1951 | 13 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 1-1952 | 14 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 5-1952 | 17 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 8-1952 | 17 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 11-1952 | 19 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 12-1952 | 23 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 3-1953 | 21 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 6-1953 | 71 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 9-1953 | 17 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 12-1953 | 71 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2-1954 | 71 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 5-1954 | 71 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 8-1954 | 71 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 11-1954 | 71 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
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### Chart #5

**A Comparison of 1975 Forecasted and Actual Average Daily Population**

**By Indiana State Mental Hospitals**

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</tr>
<tr>
<td>Richmond</td>
<td>511</td>
<td>518.3</td>
<td>7.3</td>
<td>7.3</td>
</tr>
<tr>
<td>EFCC</td>
<td>20</td>
<td>22.8</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>4,415</strong></td>
<td><strong>4,497.2</strong></td>
<td><strong>82.2</strong></td>
<td><strong>155.1</strong></td>
</tr>
</tbody>
</table>

|                |               |             |       |                |
| **Mental Retardation and Other Developmental Disabilities Hospitals** |               |             |       |                |
| Fort Wayne     | 1,174         | 1,211.9     | 37.9  | 37.9           |
| Muscatatuck    | 1,155         | 1,181.3     | 26.3  | 26.3           |
| Northern Indiana | 91           | 92.7        | 1.7   | 1.7            |
| New Castle     | 550           | 500.6       | -49.4 | 49.4           |
| **Sub-Total**  | **2,970**     | **2,986.6** | **16.6** | **115.3**   |
| **Total**      | **7,385**     | **7,483.7** | **+98.7** | **270.4**   |

**Error Mean** 8
**Error %** 1.3

**Absolute Error Mean** 21
**Absolute Error %** 3.7
<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>1976 Forecast</th>
<th>1976 Actual</th>
<th>Error</th>
<th>Absolute Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL ILLNESS HOSPITALS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beatty - Civil</td>
<td>650</td>
<td>635.2</td>
<td>-14.8</td>
<td>14.8</td>
</tr>
<tr>
<td>Beatty - MSD</td>
<td>130</td>
<td>133.0</td>
<td>+3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Carter</td>
<td>140</td>
<td>124.4</td>
<td>-15.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Central</td>
<td>630</td>
<td>609.4</td>
<td>-20.6</td>
<td>20.6</td>
</tr>
<tr>
<td>Evansville</td>
<td>550</td>
<td>608.5</td>
<td>+58.5</td>
<td>58.5</td>
</tr>
<tr>
<td>Logansport</td>
<td>825</td>
<td>870.6</td>
<td>+45.6</td>
<td>45.6</td>
</tr>
<tr>
<td>Madison</td>
<td>650</td>
<td>664.9</td>
<td>+14.9</td>
<td>14.9</td>
</tr>
<tr>
<td>Richmond</td>
<td>450</td>
<td>490.3</td>
<td>+40.3</td>
<td>40.3</td>
</tr>
<tr>
<td>EPCC</td>
<td>20</td>
<td>19.6</td>
<td>-0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>4045</td>
<td>4155.9</td>
<td>+110.9</td>
<td>213.7</td>
</tr>
<tr>
<td>MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES HOSPITALS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Wayne</td>
<td>1100</td>
<td>1098.6</td>
<td>-1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Muscatatuck</td>
<td>1015</td>
<td>1071.0</td>
<td>+56.0</td>
<td>56.0</td>
</tr>
<tr>
<td>Northern Indiana</td>
<td>90</td>
<td>87.8</td>
<td>-2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>New Castle</td>
<td>450</td>
<td>470.5</td>
<td>+20.5</td>
<td>20.5</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>2655</td>
<td>2727.9</td>
<td>+72.9</td>
<td>80.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6700</td>
<td>6683.8</td>
<td>+183.8</td>
<td>293.8</td>
</tr>
</tbody>
</table>

Error Mean 14.14
Error % 2.67

Absolute Error Mean 22.6
Absolute Error % 4.27
### Chart #7

**Forecast of Indiana State Mental Hospital Average Daily Population By Using Cohort Survival Method FY76 to FY81**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 under 5</td>
<td>5,075</td>
<td>3,999</td>
<td>.2085</td>
<td>4,066</td>
</tr>
<tr>
<td>5 years under 10</td>
<td>2,398</td>
<td>1,362</td>
<td>.2684</td>
<td>1,073</td>
</tr>
<tr>
<td>10 years under 15</td>
<td>1,606</td>
<td>1,260</td>
<td>.5254</td>
<td>716</td>
</tr>
<tr>
<td>15 years under 20</td>
<td>1,478</td>
<td>953</td>
<td>.5934</td>
<td>748</td>
</tr>
<tr>
<td>20 years under 25</td>
<td>1,167</td>
<td>894</td>
<td>.6049</td>
<td>576</td>
</tr>
<tr>
<td>25 years under 30</td>
<td>877</td>
<td>624</td>
<td>.5347</td>
<td>478</td>
</tr>
<tr>
<td>30 years under 35</td>
<td>822</td>
<td>445</td>
<td>.5074</td>
<td>317</td>
</tr>
<tr>
<td>35 years under 40</td>
<td>572</td>
<td>380</td>
<td>.4308</td>
<td>192</td>
</tr>
<tr>
<td>40 years under 45</td>
<td>341</td>
<td>211</td>
<td>.3689</td>
<td>140</td>
</tr>
<tr>
<td>45 years under 50</td>
<td>223</td>
<td>117</td>
<td>.3431</td>
<td>72</td>
</tr>
<tr>
<td>50 years and over</td>
<td>209</td>
<td>85</td>
<td>.1968</td>
<td>40</td>
</tr>
</tbody>
</table>

| Total           | 14,828                          | 10,330                           |                | 8,418                             |
## Chart #8

**Actual and Forecasted Patients Enrolled**  
By Using Component Method for  
Indiana State Mental Hospitals FY67 to FY81

### Actual

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Enrollment July 1</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Discharges</th>
<th>Enrollment June 30</th>
<th>Average Daily Population</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 67</td>
<td>18,354</td>
<td>4,876</td>
<td>958</td>
<td>3,914</td>
<td>18,358</td>
<td>14,799</td>
<td>3,559</td>
</tr>
<tr>
<td>FY 68</td>
<td>18,358</td>
<td>4,708</td>
<td>928</td>
<td>4,477</td>
<td>17,661</td>
<td>14,444</td>
<td>3,217</td>
</tr>
<tr>
<td>FY 69</td>
<td>17,661</td>
<td>4,569</td>
<td>781</td>
<td>4,746</td>
<td>16,703</td>
<td>13,294</td>
<td>3,409</td>
</tr>
<tr>
<td>FY 70</td>
<td>16,703</td>
<td>3,975</td>
<td>718</td>
<td>4,133</td>
<td>15,827</td>
<td>12,169</td>
<td>3,658</td>
</tr>
<tr>
<td>FY 71</td>
<td>15,827</td>
<td>4,036</td>
<td>599</td>
<td>4,436</td>
<td>14,828</td>
<td>11,205</td>
<td>3,623</td>
</tr>
<tr>
<td>FY 72</td>
<td>14,828</td>
<td>3,767</td>
<td>564</td>
<td>4,373</td>
<td>13,650</td>
<td>10,172</td>
<td>3,486</td>
</tr>
<tr>
<td>FY 73</td>
<td>13,658</td>
<td>3,742</td>
<td>485</td>
<td>4,049</td>
<td>12,666</td>
<td>9,224</td>
<td>3,642</td>
</tr>
<tr>
<td>FY 74</td>
<td>12,866</td>
<td>3,783</td>
<td>444</td>
<td>4,416</td>
<td>11,789</td>
<td>8,293</td>
<td>3,496</td>
</tr>
<tr>
<td>FY 75</td>
<td>11,789</td>
<td>3,972</td>
<td>376</td>
<td>4,250</td>
<td>11,135</td>
<td>7,484</td>
<td>3,651</td>
</tr>
<tr>
<td>FY 76</td>
<td>11,135</td>
<td>3,914</td>
<td>289</td>
<td>4,429</td>
<td>10,331</td>
<td>6,884</td>
<td>3,447</td>
</tr>
</tbody>
</table>

N=3,520

### Forecast

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Enrollment July 1</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Discharges</th>
<th>Enrollment June 30</th>
<th>Average Daily Population</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 77</td>
<td>10,331</td>
<td>3,900</td>
<td>284</td>
<td>4,250</td>
<td>9,697</td>
<td>9,097</td>
<td></td>
</tr>
<tr>
<td>FY 78</td>
<td>9,697</td>
<td>3,900</td>
<td>250</td>
<td>4,250</td>
<td>8,527</td>
<td>8,527</td>
<td></td>
</tr>
<tr>
<td>FY 79</td>
<td>9,097</td>
<td>3,900</td>
<td>220</td>
<td>4,250</td>
<td>7,984</td>
<td>7,984</td>
<td></td>
</tr>
<tr>
<td>FY 80</td>
<td>8,527</td>
<td>3,900</td>
<td>193</td>
<td>4,250</td>
<td>7,464</td>
<td>7,464</td>
<td></td>
</tr>
<tr>
<td>FY 81</td>
<td>7,984</td>
<td>3,900</td>
<td>170</td>
<td>4,250</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Chart #9

**ACTUAL AND FORECASTED AVERAGE DAILY POPULATION**

For

**INDIANA STATE MENTAL HOSPITALS**

**FY67 to FY81**

<table>
<thead>
<tr>
<th>Date</th>
<th>Mental Retardation and Other Developmental Disabilities</th>
<th>Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Daily Population</td>
<td>MR/DD Clients Enrolled</td>
</tr>
<tr>
<td>FY67</td>
<td>4,933</td>
<td>1,500 est.</td>
</tr>
<tr>
<td>FY68</td>
<td>4,879</td>
<td>1,700 est.</td>
</tr>
<tr>
<td>FY69</td>
<td>4,739</td>
<td>2,000 est.</td>
</tr>
<tr>
<td>FY70</td>
<td>4,572</td>
<td>2,657 est.</td>
</tr>
<tr>
<td>FY71</td>
<td>4,355</td>
<td>3,250 est.</td>
</tr>
<tr>
<td>FY72</td>
<td>4,064</td>
<td>3,927</td>
</tr>
<tr>
<td>FY73</td>
<td>3,700</td>
<td>4,595</td>
</tr>
<tr>
<td>FY74</td>
<td>3,298</td>
<td>5,971</td>
</tr>
<tr>
<td>FY75</td>
<td>2,987</td>
<td>7,265</td>
</tr>
<tr>
<td>FY76</td>
<td>2,728</td>
<td>6,948</td>
</tr>
</tbody>
</table>

**FORECAST**

<table>
<thead>
<tr>
<th>Date</th>
<th>Average Daily Population</th>
<th>MR/DD Clients Enrolled</th>
<th>Family Care Patients</th>
<th>Average Daily Population</th>
<th>Outpatient Terminations</th>
<th>Family Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY77</td>
<td>(2,540)</td>
<td>8,000</td>
<td>600</td>
<td>(3,537)</td>
<td>25,500</td>
<td>1,000</td>
</tr>
<tr>
<td>FY78</td>
<td>(2,353)</td>
<td>8,500</td>
<td>625</td>
<td>(3,130)</td>
<td>26,500</td>
<td>1,075</td>
</tr>
<tr>
<td>FY79</td>
<td>(2,167)</td>
<td>9,000</td>
<td>650</td>
<td>(2,724)</td>
<td>27,500</td>
<td>1,150</td>
</tr>
<tr>
<td>FY80</td>
<td>(1,980)</td>
<td>9,500</td>
<td>700</td>
<td>(2,341)</td>
<td>28,500</td>
<td>1,200</td>
</tr>
<tr>
<td>FY81</td>
<td>(1,792)</td>
<td>10,000</td>
<td>750</td>
<td>(1,959)</td>
<td>29,500</td>
<td>1,250</td>
</tr>
</tbody>
</table>
# Chart 10

**Actual and Forecasted Average Daily Population**

**By**

**Indiana State Mental Hospitals, 1976-81**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Beatty - Civil</td>
<td>635.2</td>
<td>575</td>
<td>550</td>
<td>525</td>
<td>525</td>
<td>525</td>
</tr>
<tr>
<td>Beatty - MSD</td>
<td>133.0</td>
<td>110</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Carter</td>
<td>124.4</td>
<td>130</td>
<td>130</td>
<td>130</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Central</td>
<td>609.4</td>
<td>550</td>
<td>525</td>
<td>525</td>
<td>525</td>
<td>525</td>
</tr>
<tr>
<td>Evansville</td>
<td>608.5</td>
<td>550</td>
<td>525</td>
<td>500</td>
<td>450</td>
<td>400</td>
</tr>
<tr>
<td>Logansport</td>
<td>870.6</td>
<td>775</td>
<td>725</td>
<td>675</td>
<td>625</td>
<td>575</td>
</tr>
<tr>
<td>Madison</td>
<td>664.9</td>
<td>625</td>
<td>575</td>
<td>525</td>
<td>475</td>
<td>450</td>
</tr>
<tr>
<td>Richmond</td>
<td>490.3</td>
<td>500</td>
<td>475</td>
<td>450</td>
<td>425</td>
<td>400</td>
</tr>
<tr>
<td>EPCC</td>
<td>19.6</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>4,155.9</strong></td>
<td><strong>3,835</strong></td>
<td><strong>3,625</strong></td>
<td><strong>3,450</strong></td>
<td><strong>3,275</strong></td>
<td><strong>3,100</strong></td>
</tr>
</tbody>
</table>

**Mental Retardation and Other Developmental Disabilities Hospitals**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fort Wayne</td>
<td>1,098.6</td>
<td>1,000</td>
<td>950</td>
<td>900</td>
<td>850</td>
<td>800</td>
</tr>
<tr>
<td>Muscatatuck</td>
<td>1,071.0</td>
<td>1,000</td>
<td>950</td>
<td>900</td>
<td>850</td>
<td>800</td>
</tr>
<tr>
<td>Northern Indiana</td>
<td>87.8</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>New Castle</td>
<td>470.5</td>
<td>450</td>
<td>425</td>
<td>400</td>
<td>375</td>
<td>350</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>2,727.9</strong></td>
<td><strong>2,540</strong></td>
<td><strong>2,415</strong></td>
<td><strong>2,290</strong></td>
<td><strong>2,165</strong></td>
<td><strong>2,040</strong></td>
</tr>
</tbody>
</table>

**All Hospitals**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>6,883.8</strong></td>
<td><strong>6,375</strong></td>
<td><strong>6,040</strong></td>
<td><strong>5,740</strong></td>
<td><strong>5,440</strong></td>
<td><strong>5,140</strong></td>
</tr>
</tbody>
</table>
Introduction

On the most basic level, program evaluation must proceed from an understanding of the philosophical underpinnings of a program. Until the philosophy of a given plan is clearly understood, the success of programs instituted to effect that plan cannot be assessed. Programs must, after all, be evaluated according to how well they implement the philosophy from which they have evolved.

In mental health, the dominant theme in program planning over the past decade has been deinstitutionalization of services. Numerous programs have been designated and instituted in an effort to meet the demands and goals of the deinstitutionalization movement; but relatively little has been written about the subtleties of the philosophy underlying the movement. Consequently, many program plans have proceeded in something akin to a conceptual vacuum. Needless to say, it has been difficult to evaluate the effects of these programs in any fundamental sense.

This paper represents an attempt to articulate the philosophy of the deinstitutionalization movement in mental health by presenting a conceptualization of the issues and problems which have arisen. It shows that failure to get a broad philosophical perspective on the movement has resulted in difficulties in program implementation. Finally, it concludes that an appreciation of the conceptual dimensions of the movement is the sine qua non of effective program planning in mental health.
Toward a Definition of Deinstitutionalization

The term, deinstitutionalization, though widely used, is rarely defined. In practice, it is variously used to refer to a broad scope of patient-connected events, ranging from carefully planned local efforts at community care, to mass releases of patients into communities, as State hospitals have been "phased out" or closed. That disparities in usage of the term exist results from the fact that deinstitutionalization is an extremely complex phenomenon. Each individual involved with deinstitutionalization tends to know best — or perhaps exclusively — only that portion of the movement with which he is personally involved. Accordingly, it is well to begin any discussion of deinstitutionalization with a definition of the term.

Deinstitutionalization may be defined as a process involving two elements — (1) the eschewal, shunning or avoidance of traditional institutional settings, primarily State hospitals, for the care of the mentally ill; and (2) the concurrent expansion of community-based services for the treatment of these individuals.

This definition, by focusing on physical properties — i.e., the locations where mental health services are provided — describes the operational aspects of deinstitutionalization. Postulating such a definition may be viewed as a first step in establishing a conceptual framework for understanding the deinstitutionalization movement. The definition, by itself, affords enough shared understanding to remind mental health practitioners that deinstitutionalization is not a unilinear phenomenon encompassing only the release of patients from mental hospitals. Rather, it is a more general term which involves, in addition to hospital releases, an exchange in the locations of mental health care.
In addition, this definition also provides a base from which the more subtle implications of the deinstitutionalization movement may be explored. It suggests that there is more to deinstitutionalization than its locational aspects and implies that deinstitutionalization is best understood as a movement possessing dynamic qualities.

Elements of Deinstitutionalization

At least three separate, but interrelated, basic elements in the deinstitutionalization movement may be isolated: (1) deinstitutionalization as a process; (2) deinstitutionalization as a philosophy; and (3) deinstitutionalization as a fact.

Deinstitutionalization as a process -- Deinstitutionalization, rather than being an isolated event, is a dynamic and continuing series of adjustments and accommodations. All components of the mental health service delivery system are involved. Physically, the process may be set in motion in the mental hospital, through the release of those already hospitalized. Or it may begin in the community through the prevention of hospitalization by provision of community-based alternative services. Wherever it starts, the process, once begun, continues. The idea of a "continuum of care" that is so closely associated with the community mental health movement is a reflection of the dynamic quality of deinstitutionalization. Ideally, at least, with deinstitutionalization the patient is permitted to move freely from facility to facility, or even in and out of the service delivery system. His current needs will determine his utilization patterns.

Deinstitutionalization as a philosophy -- When deinstitutionalization is viewed as a process, its intellectual foundation begins to become appare...
The deinstitutionalization movement is the expression of a philosophy current in American thought. This philosophy places strong civil libertarian emphasis on the rights of patients and on the modification of environment as the primary avenue to humane patient care (1).

The philosophy of deinstitutionalization proceeds from at least three fundamental assumptions concerning mental health care. First, there is an assumption that community mental health is a good thing — that community-based mental health care is preferable to institutionalized care for most, if not all, mental patients. Community care is perceived as the more therapeutic alternative, and it represents the treatment of choice in most cases of mental illness.

A second underlying assumption is that functions performed by the mental hospital can be equally—if not better—performed by community-based facilities. The idea of deinstitutionalization, in other words, implies that the community is capable of providing, outside of institutional settings, those patient services which are available within the hospital.

Finally, deinstitutionalization is based upon an assumption that communities not only can, but also are willing to, assume responsibility and leadership in the care of the mentally ill.

These three philosophical assumptions, taken together, permit an understanding of the charge of deinstitutionalization. The operational definition proposed earlier, with its emphasis on the locational aspects of patient care, may now be supplemented with a goal definition. The goal of deinstitutionalization is lofty and is rooted in the philosophy of the movement. Deinstitutionalization has assumed no less a task than that of "humanizing" mental health care—a task which would reverse the dehumanizing influences of institutionalizing the mentally ill.
Deinstitutionalization as a fact -- Deinstitutionalization, then, is both a process and a philosophy. But it is something more as well: it is also a fact. The movement toward community-based care in this country has a reality dimension that cannot be overlooked. Although this paper is primarily concerned with the conceptual aspects of deinstitutionalization, brief mention may be made of some statistics which provide evidence for deinstitutionalization as a fact.

In 1955, about half of the psychiatric patient care episodes in the Nation occurred in State mental hospitals; (2) but in 1973 the percentage was less than one-fifth (Table 1). On the other hand, outpatient services accounted for only 23% of psychiatric patient care episodes in 1955 but for as many as two-thirds of all episodes in 1973. Federally funded community mental health centers, which did not even exist prior to the passage of the Community Mental Health Centers Act of 1963, accounted for 23% of psychiatric patient care episodes in 1973 (2).

There has also been a dramatic decrease in the size of State hospital resident populations. The number of resident patients in State mental hospitals peaked at over half-a-million in 1955. It has been decreasing ever since. In 1975, the number of State mental hospital residents was only about 193,000 (3,4).

Functions of the Mental Hospital

Acknowledgment and consideration of these properties of deinstitutionalization — process, philosophy and fact — permit a framework for better understanding of the issues in the deinstitutionalization movement. Were deinstitutionalization merely an event with locational referents — were it concerned only with the exchange of settings for patient care —
many of the problems associated with the movement would not have arisen. The community would merely have replaced the hospital as the locus of care, and resultant problems would have been of a logistical nature, easily negotiated and resolved.

In fact, however, deinstitutionalization has, since its inception, confronted obstacles every step of the way. There are numerous issues associated with deinstitutionalization of the mentally ill, and experience of the past decade has demonstrated that these issues have been extremely difficult to resolve. It is not the intention of this paper to rehash the issues in deinstitutionalization; this has been done often and with great skill in the literature. A recent publication (5) proposes a taxonomy of issues in deinstitutionalization and provides brief summaries and appropriate bibliographic citations. The taxonomy of issues provided in Figure 1 is based on that work.

(Figure 1 about here)

In the preceding discussion of deinstitutionalization as a philosophy, it was noted that one underlying assumption of the movement is the premise that functions served by the mental hospital can be equally, if not better, performed in community-based facilities. What, exactly, are these functions? A review of the literature suggests that the range of functions realized by mental hospitals is surprisingly complex and is far more extensive than might be supposed. While treatment, asylum and custody are the functions most often associated with institutional care (6), the literature reveals a whole series of additional functions that are less readily observed (7,8,9,10,11,12). It is safe to say that some of these functions were not originally intended but have evolved naturally as the system of institutional care has grown in this country.
An attempt to isolate some of the functions of the mental hospital as identified in the literature yields 19 separate items (5). This listing, shown in Figure 2, is limited to those functions explicitly stated in the literature. Were it to be expanded by the inclusion of such functions as are also implicit in the literature, it would be even longer. The listing includes the widely acknowledged function of providing long-term care for chronically disturbed individuals. It also includes some other functions that are perhaps less often perceived or acknowledged — like rendering relief to the patient’s family and providing a sort of hiding place outside the community for some of its less attractive members.

An important observation emerges when the listing of mental hospital functions presented in Figure 2 is compared with the issues in deinstitutionalization classified earlier in Figure 1. The issues in deinstitutionalization fall into two major groupings vis-a-vis mental hospital functions. Either: (a) the issue has at least one referent among the functions listed, or (b) the issue has come into being as a latent function — an unanticipated consequence — of the deinstitutionalization movement itself. With respect to the former grouping, it is apparent from a review of the literature (5), that efforts to reduce the stature of, or eliminate, mental hospitals have placed disproportionate emphasis on the function of treatment and have too often neglected to stress the necessity for alternatives to the custodial and other functions of mental hospitals. It is inevitable that any movement which so ignores the institutional makeup of society will encounter severe opposition.

With respect to the latter grouping of issues — those which emerge
as products of the movement itself — it is apparent that the deinstitutionalization effort in process has not been viewed by its champions with sufficient detachment to permit program planners to recognize problems and introduce necessary modifications. Deinstitutionalization has left in its wake a series of dysfunctional elements which result directly from rapid, and sometimes heedless, implementation of the movement. (13)

Efforts to replace mental hospitals with community-based facilities have too often taken place in a sort of functional vacuum. They have too frequently failed to stress the necessity for providing alternatives to the range of mental hospital functions and focused only on the function of providing treatment. Although mental health practitioners may be reluctant to acknowledge that some of the other functions have been part of the mental health care system, denial alone will not make them disappear. (14)

However, the tide appears to be turning. Early literature on deinstitutionalization, which reflected the mood underlying program planning in the 1960's, largely ignored or discounted the extra-treatment functions of mental hospitals. Recognition of the functions of asylum and custody, and of the other functions listed in Figure 2, has become more and more prevalent in the literature of the mid-1970's. Thus, Slovenko and Luby (14) write:

The medical model terminology has been misleading. When we use the term "hospital," we naturally think of treatment. Hospitalization without treatment is an absurdity. If, however, we understand by the term "hospitalization" nothing more nor less than asylum (as the mental hospital at one time was called), a place of refuge, there is no connotation of medical treatment but rather one of treatment in the broad sense as meaning "handling of" or "how we treat one another."
Conclusions

It is frequently forgotten that deinstitutionalization, for all its positive thrust, is basically a protest movement. Deinstitutionalization is best understood as the obverse of institutionalization. It follows, therefore, that comprehension of the sociology of mental institutions is prerequisite to understanding the nature of deinstitutionalization. A basic assumption underlying the philosophy of the deinstitutionalization movement — that the community can and will provide alternatives for the range of functions performed by the mental hospital — has been shown, through functional analysis, to be, at best, fuzzily conceived. Functional alternatives for the mental hospital cannot be provided nor effected by the community until the totality of functions is, first, understood; second, acknowledged; and, finally, dealt with in the planning process.

After more than a decade of deinstitutionalization efforts, it is now necessary to take a fresh look at the deinstitutionalization movement. The issues which have emerged need to be faced squarely, so that the movement can pursue its goal of counteracting the dehumanizing effects of hospitalization. In summary, mental hospitals can be effectively superseded only when:

(1) there is an objective and thorough understanding of the functions which they serve in American life; (2) consensus is reached as to which of these functions should be continued or discontinued, or which new functions should be added; (3) effective alternatives are established in community settings for the accepted functions; and (4) sufficient time is allowed for the systematic and orderly implementation of new programs and transfer of functions.
REFERENCES


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6. Edwards RM: Functions of the state mental hospital as a social institution. Mental Hygiene 48:666-671, 1964 (October)


8. Fowlkes MR: Business as usual — at the state mental hospital. Psychiatry 38:55-64, 1975 (February)


Table 1. Number and percent distribution of patient care episodes by type of facility and modality, mental health facilities, United States 1973

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>All Services</th>
<th>2/ Day Treatment</th>
<th>All Services</th>
<th>2/ Day Treatment</th>
<th>All Services</th>
<th>2/ Day Treatment</th>
<th>All Services</th>
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<tr>
<td>Non-Federal Psychiatric Hospitals</td>
<td>1,205</td>
<td>775</td>
<td>403</td>
<td>27</td>
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<td>45.1</td>
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<td>State and County Hospitals</td>
<td>1,014</td>
<td>652</td>
<td>339</td>
<td>23</td>
<td>19.5</td>
<td>38.0</td>
<td>9.5</td>
<td>12.4</td>
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<td>Private Hospitals</td>
<td>191</td>
<td>123</td>
<td>64</td>
<td>4</td>
<td>3.5</td>
<td>7.1</td>
<td>1.8</td>
<td>2.1</td>
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<tr>
<td>A Psychiatric Services</td>
<td>362</td>
<td>208</td>
<td>144</td>
<td>9</td>
<td>6.6</td>
<td>12.1</td>
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<tr>
<td>Neuropsychiatric Hospitals</td>
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<td>91</td>
<td>60</td>
<td>1</td>
<td>2.8</td>
<td>5.3</td>
<td>1.7</td>
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<td>General Hospitals</td>
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<td>117</td>
<td>84</td>
<td>9</td>
<td>3.8</td>
<td>6.8</td>
<td>2.3</td>
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<td>on-Federal General Hospitals</td>
<td>999</td>
<td>475</td>
<td>489</td>
<td>35</td>
<td>18.3</td>
<td>27.6</td>
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<td>18.8</td>
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<td>142</td>
<td>238</td>
<td>18</td>
<td>7.3</td>
<td>8.2</td>
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<td>9.7</td>
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<td>Nonpublic Hospitals</td>
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<td>251</td>
<td>17</td>
<td>11.0</td>
<td>19.4</td>
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<td>Residential Treatment Centers for Emotionally Disturbed Children</td>
<td>53</td>
<td>29</td>
<td>22</td>
<td>2</td>
<td>1.0</td>
<td>1.7</td>
<td>0.6</td>
<td>1.1</td>
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<tr>
<td>Federally Funded CHHC's</td>
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<td>192</td>
<td>903</td>
<td>81</td>
<td>22.9</td>
<td>11.2</td>
<td>27.5</td>
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<td>Other Multiservice Mental Health FAC</td>
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<td>39</td>
<td>120</td>
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<tr>
<td>Public</td>
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<td>5.4</td>
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<td>Free-Standing Day/Night Facilities</td>
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<td>-3</td>
<td>4</td>
<td>0.1</td>
<td>-</td>
<td>0.1</td>
<td>2.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

1/ Excludes partial care other than day treatment services

2/ Does not include outpatient care provided in private psychiatric office practice

Figure I

A Taxonomy of Issues in Deinstitutionalization

I. Issues related to the selection of patients for community care
   A. Chronically ill patients
   B. Patients inadequately prepared for life in the community
   C. Disadvantaged and minority groups

II. Issues related to the treatment course of patients in the community
   A. Inadequate range of treatment services
   B. Fragmentation and lack of coordination in community treatment services
   C. Inaccessibility of treatment services
   D. Questionable quality of care in community services

III. Issues related to the quality of life of patients in the community
   A. Inadequate community support systems
   B. Residential facilities and living arrangements

IV. Issues related to the greater community
   A. Community resistance and opposition to mentally ill individuals
   B. Effects on communities to which patients are released
   C. Ecological impacts on economy of hospital community and on hospital staff
   D. Effects on patient's family

V. Issues related to the training and re-training of staff for community work

VI. Financial and fiscal issues

VII. Legal and quasi-legal issues

VIII. Informational issues and accountability
   A. Necessity for evaluation studies
   B. Difficulties in locating and following patients in the community
   C. Inadequacy of existing follow-up studies

IX. Additional issues resulting from the process of deinstitutionalization itself
   A. Timing: precipitate implementation of new programs
   B. Inadequate attention to patients' desires
   C. Problems related to providing adequate services in hospitals during phase-out
   D. Failure to establish liaison between hospitals and community-based facilities
   E. Role-blurring
   F. Disenchantment with the deinstitutionalization movement: resistance to further change

Figure II
Functions of Mental Hospitals *

Providing long-term care for chronically disturbed individuals
Providing for the patient respite from mounting pressures
Removing the patient from his regular environment and whatever pathological influence that environment may have
Protecting the patient from exploitation by others
Providing a residential environment for the mentally ill
Providing constant and continuous monitoring and review of the patient's course of illness
Providing a social structure within which the role of the mentally disturbed individual is clearly defined
Providing the mentally ill individual with an alternative to due process of law
Providing the patient with a place to which he may escape from the greater society
Providing a means by which society can segregate some of its deviants
Relieving the patient's family and community from disruptive social interaction
Protecting society from the acts of dangerous individuals
Supplying an ostensibly relatively inexpensive form of patient care
Providing an economic base and employment for a community or a portion of a community
Providing for numbers of employed persons job security and other job perquisites
Providing a tax base for local communities
Providing for mental health professionals a "siphon(ing) off (of) the least affluent and least attractive mentally disturbed" (8)
Creating an "illusion that all local mental health needs are being met, thus eliminating the need for...local planning and spending for mental health care" (8)
Providing a place for research on mental illness and training of mental health professionals

DEINSTITUTIONALIZATION: A CONCEPTUAL FRAMEWORK

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Based on seminar presentations at: Second Annual Statewide Outreach Conference, Terrell State Hospital, Terrell, Texas, August 1976; Workshop on "The Impact of Deinstitutionalization on Rural Programs," National Council of Community Mental Health Centers Meetings, Atlanta, Georgia, February-March 1977; Workshop on "Deinstitutionalization and Aftercare Techniques," University of North Carolina Division of Community Psychiatry, Chapel Hill, North Carolina, March 1977.
A STAFF DEVELOPMENT PROGRAM
IN INDIANA STATE MENTAL HOSPITALS
BY 1980

Introduction

The purpose of this paper is to develop a staff development program for the twelve state mental hospitals operated by the Indiana Department of Mental Health for the year 1980. After a brief discussion of the Department of Mental Health as it exists in 1975, a forecast will be made of future mental health needs. A staff development recommendations.

State Hospital System, 1975

The Indiana General Assembly appropriated 177.4 million dollars for operating and capital expenditures to the Indiana Department of Mental Health for the 1973-75 biennium. Approximately 145.3 million dollars are for the operation and capital expansion of twelve state hospitals. Thus, almost 80% of the Department's budget is used to support state hospitals. The remaining 20% is for the support of a variety of community programs including community mental health centers and facilities for the mentally retarded and other developmentally disabled.

There are twelve state hospitals located at various sites in Indiana with a combined April, 1975, patient present population of 7,245 individuals.

Approximately 7,400 full-time employees and 370 part-time employees, plus consultant staff were employed in the state hospitals in March, 1975. The majority of staff members are paraprofessional
attendants plus institutional workers with a professional staff composed of a variety of clinical disciplines and administrators.

There is some type of staff development program within each hospital with a minimum overall coordination from the Central Office of the Department of Mental Health. Staff development positions and funds have not received financial support from the General Assembly. However, a staff development program is currently being formulated between the Department of Mental Health and the School of Public and Environmental Affairs of Indiana University. Since a staff development program is being developed for the current delivery system, the investigation will develop recommendations for a forecasted future system.

Forecast

The patient present population in the Indiana state mental hospitals has been declining at a steady rate since 1967. (See chart in Appendix.) The June, 1966, census was 14,887 patients as compared with a June, 1974, census of 7,736. This represents a reduction of 7,151 patients. The national data for state and county mental hospitals plus public institutions serving the mentally retarded show a similar decline in census.

Assumptions for the State Hospital Delivery System

1. The General Assembly will not decide to close a state hospital by 1980. All twelve hospitals will be operational, however the patient population in the larger hospitals will be reduced.
2. The incidence and prevalence of mental illness, mental retardation and other developmental disabilities, alcoholism and drug abuse will continue at the current rates.

3. There will be a constant proportion of the State's population at high risk (the poor and socially disadvantaged, unemployed, and others) which produce state hospital patients at a high rate.

4. There will be increased acceptance of the mentally ill person, the mentally retarded and developmentally handicapped individual, the alcoholic, and the drug abuser in his or her home community when proper treatment and support services are available.

5. There will be sufficient funds appropriated by the Federal, State and local legislative bodies to construct and operate the planned 32 community mental health centers, community residential facilities and halfway houses for the mentally ill, day and residential facilities for the mentally retarded and developmentally disabled, plus outpatient and inpatient facilities for those persons with addiction problems.

6. Mandatory special education in the public schools will reduce the number of emotionally disturbed school age children and adolescents entering the state hospital system. A similar effect would occur for mentally retarded children and adolescents.

7. There will be a gradual increase in the number of current state hospital patients placed on Family Care status.

8. There will be a sizeable expansion of the number of halfway houses, small group homes, and other community residential services for
the mentally ill, plus the mentally retarded and developmentally handicapped patient. The full impact of such a development will not be felt until 1978.

9. The mental health service delivery system, both state hospital and community components, will become increasingly more effective and efficient which will result in a reduced need for long-term state hospital care and treatment, plus the average length of stay in a state hospital will be reduced.

10. A national health insurance program will have a significant impact in lowering the number of patients served in state mental hospitals. This insurance program with mental health benefits will become law, June, 1976. The full impact of this program will be felt by state hospitals by January, 1978.

A forecast was made in another study by the investigation using the above national data and assumptions plus other quantitative data and forecasting techniques. The resultant forecast was a further decline in state hospital population and a 1980 census figure of 5,200 patients. (See Appendix.) While this forecast may not be entirely accurate, such a decline in population will cause problems within the organization (Indiana Department of Mental Health) and community organizations. A well organized staff development program could assist the Indiana Department of Mental Health to help solve the problem ramifications of such a forecasted decline.
Ramiifications of the Forecast and Recommendations

1. There will be a good chance that the General Assembly may appropriate less funds for Personnel Services than they did for the 1974-75 Fiscal Year. Additional justification may be needed as to why state hospitals will require the same or more staff while the number of patients continues to decline.

Recommendation

1A. The Department should do manpower study on the number and qualifications of staff needed to provide a high level of treatment services in the state hospitals by 1980. Included in this study is to establish standards and appropriate evaluation techniques to determine services needed and manpower requirements to deliver these services. The study should also include a discussion of the effect of the Wyatt-Stickney Standards if they are required as a result of a "right to treatment" suit against the State of Indiana.

1B. A full-time adult educator should be assigned to the Central Office of the Indiana Department of Mental Health. This person would be responsible for organizing a staff development program for the twelve state hospitals as well as spending a major portion of his or her time in working with the community agencies (board, staff and clients) which are a part of the mental health delivery system.

1C. An adult educator should be on the staff of each state hospital to develop and implement staff development programs for the hospital as well as community agencies who relate to the state hospital.
1D. A survey should be made of the employees of the Indiana Department of Mental Health to determine their staff development needs at this point in time (April, 1975). This information would provide baseline data for a staff development program to meet the needs of the mental health delivery system in 1980.

1E. There should be a continuous staff development program organized to meet the changing needs of the state hospitals. The staff development program should include such things as pre-service and inservice training programs, self-study, planned work experiences, visits to other state hospitals and community agencies (including out-of-state trips) horizontal transfers within the state hospital system and the Central Office, exchange employee program within state government, unity agencies, participation in state and national professional organizations, attendance at state, regional, and national conferences, encouragement of applied research and the publication of the findings by an in-house publication or national periodicals, and other such adult learning experiences to enable the employee to be more valuable to the state hospital.

1F. The adult educator at the Central Office level and at the state hospital should recognize the Department of Mental Health as a social organization as well as a unit of state government. There is a very definite informal structure that exists with the formal table of organization. There is a large number of employees with many years of service who know each other. The adult educator will need to be able to work with the informal system, especially if the organization is threatened with lay-offs or closing of a hospital. The Central Office needs to recognize that, while he may have authority, he will need to
earn the power to implement his programs within a state hospital managed often by a medical doctor with considerable independence. Each hospital has its own social system and relationships to community agencies. The reference groups of many of the staff may be more concerned with in-hospital programs rather than hospital-community activities. However, the reference group of newer staff members may be oriented toward community programs without an understanding of the possible contributions of a state hospital. A staff development should address both situations.

As state hospitals become smaller there may occur a change in a state hospital. Some state hospitals have already moved from departmental to an unit system. More personnel will be working with community agencies and some departments, such as nursing, dietary, maintenance, and others will lose employees.

I6. As state hospitals become smaller they will become more multi-purpose and serve mentally ill, mentally retarded and developmentally disabled, the drug abuser and alcoholic. A staff development program will need to upgrade the clinical skills to serve patients who have traditionally not been served in a particular state hospital. State hospitals that have formerly served mainly the mentally ill will have additional mentally retarded patients. State hospitals that have specialized in serving them, mentally retarded may need to serve the mentally ill patient.

I7. More attention should be given to public education and information by the adult educator. The consumer of the services and the general public should have a better understanding of mental health (as opposed to mental illness) and should know what to expect if they seek professional services for an emotional problem.