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Forgotten or Abandoned: The Policies of Deinstitutionalization and its Effects on Homeless Populations

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As the homeless epidemic in the United States grows larger, so too does the moral imperative to address it. The origins of the dynamic nature of the homeless population are found not only in an increasing amount of the downtrodden, but also as the result of key failures at multiple levels of government and society with regards to deinstitutionalization. This process, by which government-run mental health institutions were phased out in favor of a more local and community-based model, can be assigned some culpability for the current state of homeless affairs. To be explored will be a catalog of different legislation implemented within the United States at Federal, state, and local levels, which ultimately lacked the necessary foresight and contributed to the current state of crisis. Attention will be paid to judicial rulings which, similarly across different jurisdictions, illuminate the shifts in legal reasoning towards the mentally ill and the homeless. Third, a discrepancy in the healthcare profession will be examined, looking to identify the causes of why guidelines for care were potentially too idealistic and how the perception of institutions may have caused doubts in these facilities to arise. The decline in social services in the United States in the later decades of the 20th century will be shown to have exacerbated the already growing dilemma. Finally, the political realities surrounding housing policy will seek to explain, in part, another confounding variable that, in tandem with deinstitutionalization, continues to make worse the problem of homelessness.

This paper will aim to show how the above factors related to deinstitutionalization combined to help cause the current crisis of homelessness in the United States. Similar undertakings have also occurred in other nations, the United Kingdom for example, and their more successful model will highlight specific critical points of American failure. Moreover, the above causes are all united in their context, and special attention will be paid to the importance of rhetoric and perception in their developments. The percolation of a dynamic culture, the result

of a shifts in perception, resulted in the legislative and judicial changes noted above. A short survey of the current political situation in California will illustrate the importance of action and the moral imperative that awaits

Insofar as it pertains to the United States, perhaps the notion most pervasive associated with determining the rise of homelessness and the mentally ill in during the 1970s is the common belief that one of the largest contributing factors was deinstitutionalization. At this point in time, nearly all Americans held coverage under some form of entitlement for decades. The Great Depression and subsequent New Deal initiatives provided the funding needed for progressive social policies, ensuring that a safety net would be placed below the lowest in society. In *the Homeless in Contemporary Society* Richard Bingham writes of his belief that this common understanding was fundamental in later facilitating and enabling the disorder that followed deinstitutionalization. He references an American society prior to the Great Depression when economic welfare was administered through nongovernmental means, largely charitable organizations. He writes "With the collapse of the American economy during the Great Depression, the federal government finally had to assume responsibility for the task of providing relief for economic distress. It did so only after the voluntary organizations and state and local governments had been nearly destroyed through the collapse of their funding sources."[1] Bingham believes that the rise of federal responsibility, which later increased with the legislation of the of the Great Society in the 1960s and the war on poverty, further weakened the demand and ultimately the services provided, of charitable organizations. The result was a government that, for all intents and purposes, assumed a role of primary caretaker. When institutions began to be scaled down the Federal government looked to absolve itself of responsibility, passing the

[1] Bingham, Richard D., Roy E. Green, and Sammis B. White. *The Homeless in Contemporary Society*. Newbury Park, CA: Sage Pub., 1991, 134.

responsibility to on the charitable and community organizations. This notably includes religious organizations, which merits a section in itself and will be further discussed at length. Following deinstitutionalization however, such organizations lacked the infrastructure necessary to address with the issue. It was the unexpected outbreak of poverty caused by deinstitutionalization of the 1970s that sent a shockwave through the third sector. There was little infrastructure and the demand for services were too great for the paltry services offered. As a result, the most marginalized continued to be so. The problems of the mentally ill and later homelessness became inevitable.

In support of the theory that it was deinstitutionalization itself as the primary factor directly responsible for the crisis was that a significant population of the rise of homeless during this time period consisted of Vietnam war veterans. As the United States struggled to separate their feelings about the war and about those who served in the war, many veterans found themselves outcast from their community and ignored by the government.[2] This rejection from society carried with it the implication of societal expectations. This at-risk group was exceptionally predisposed to homelessness.

The process of deinstitutionalization in the United States was fairly brief. Despite the effective period of deregulation and removal of government run facilities and mental institutions was completed in under a decade, the consequences and repercussions, direct or otherwise, that emerged continued to implicate the good intentions of the time well into the end of the twentieth century. Homelessness rose sharply after the deinstitutionalization of the 1970s, which had initially intended to return the mentally ill to their communities, where they were to be more individually treated. This belief of community-based care has its origins in the American

[2] Rosenheck, R., P. Gallup, and C. A. Leda. "Vietnam Era and Vietnam Combat Veterans among the Homeless." *American Journal of Public Health* 81, no. 5 (1991): 643-46. Accessed May 7, 2018.

movement for deregulation, although a separate and similar movement can also be found in the United Kingdom, which is discussed elsewhere. The approaches to addressing homelessness have demonstrably evolved over the decades of the late 20th century. The perception of the crisis of homelessness had an undeniable effect on policy; it drove the intent behind the contemporary laws. To this extent, some of the laws enacted responding to vagrancy and destitution were based in the notion that mental illness was elective in nature.[3] Those that intended to repel from urban areas, such as policies that fined or arrested the homeless, were clearly authored with the intent of excluding these individuals from communities. The mentally ill were not considered members of their own community so much as they were outsiders drawn to prosperity, reinforcing the belief that these persons were parasitic in their drain on community resources. One contentious and defining example of this was the 1983 California state law which empowered peace officers to make the determination if a loiterer was doing so rightfully and permitted their arrest otherwise.

In 1983, the United States Supreme Court, in *Kolender v. Lawson*, ruled against a standing California law which had empowered peace officers in the state. The legislation made it so that any person suspected of loitering or wandering in public areas, if confronted by peace officers, would be compelled to provide credible and reliable identification, if requested by the officer. Furthermore, that person would also need to account for their presence. The Supreme Court however, held that this was unconstitutional through its vagueness on two issues, together violating the Due Process clause of the 14th amendment. The first is its vagueness in defining to the obligations of the stopped party, especially in determining what constitutes credible and reliable information. The second reason is due to the failure to establishing any limits, in lieu of

[3] Timmer, Doug A., D. Stanley Eitzen, and Kathryn D. Talley. *Paths to Homelessness: Extreme Poverty and the Urban Housing Crisis*. Boulder, CO: Westview, 1994, 15.

any test, discretion is ceded to the peace officer to make that decision and carry out its enforcement.

Although the ruling itself is notable for how it curbed state power in regard to dealing with wanderers, and by effect the vagrant, it reflects more the changing legal reasoning that is applied when talking with regards to vagrancy. For example, when, in the oral arguments, Justice Stevens questions the intent and implications of the 647(e) (the California State law) in what it attempts to solve. He says the following, "As I understand your explanation of the statute, without any Miranda warning or its equivalent, if a man who is in fact suspected of committing a crime is stopped and asked if he was at the location of the crime and he just says, I'd rather not answer, he's now committed the offense."[4]It is here established that, insofar as one Justice articulates and is later confirmed through the majority vote, that one cannot be compelled to provide information to the peace officer until it reaches the threshold for verifying 'reliable information.' Furthermore, no threshold was there established, adding to the vagueness. This contrasts with other legal rulings of previous eras, when the recognition of the public interest, defined in many ways, afforded little flexibility to the individual rights of those interacting with the police. This reflects the changing opinion in American legal doctrine in shifting towards individual rights and away from public interest, perhaps a vestigial feature from its shared legal history in the common law tradition.

One such American ruling from a different era that exemplifies a different line of reasoning is *Mayor of New York v. Miln*. In 1837, the majority opinion Justice Barbour wrote that, "[the state is] to provide precautionary measures against the moral pestilence of paupers, vagabonds, and possible convicts, as it is to guard against the physical pestilence, which may arise from

[4] "Kolender v. Lawson." Oyez. Accessed October 24, 2019. https://www.oyez.org/cases/1982/81-1320.

unsound and infectious articles imported."[5] This restrictive perspective on individual liberties in place of the common good is evocative of the common law tradition and its English heritage. This can be understood in the context of American legal history largely through the ideas of public health, safety, and welfare. By enabling the state to remove the 'petulant' from public areas, they are thereby endorsing the notion and supremacy of the common good. The fact that this was later revered in the twentieth century further demonstrates how this model slowly came to be rejected by the American judiciary. In *Mayor of New York v. Miln*, rather than insist on the demonstration of wrongdoing, as was one defining characteristic of *Kolender v. Lawson,* the USSC ruled that the potential of wrongdoing was enough to permit action on behalf of the state. These two rulings, together and in context, illuminate the changing reasoning happening at the highest level of the judiciary over time.

Another point of interest in determining the extent to which academia and public policy continue their relationship in the context of this topic is with a close scrutiny of its legal history. One later example, the 1962 United States Supreme Court case, *Robinson v California,* held that do not possess the authority to criminalize the act of mental illness. The reasoning provided by the court likened the California statute to making it a criminal offense "to be mentally ill, or a leper, or to be afflicted with a venereal disease."[6] Henceforth, laws that were developed by states and local communities could no longer criminalize destitution itself; rather, many communities adopted an indirect manner of justifying criminalization. One example could include activities such as sleeping in places of public interest, such as the sidewalk, sleeping in one's vehicle, or near public transportation. This indirect form of criminality would later be challenged in Los Angeles County using the common law defense of necessity, resulting in the aforementioned

[5] "Mayor of New York v. Miln." Oyez. Accessed October 27, 2019. https://www.oyez.org/cases/1789-1850/36us102.
[6] "Robinson v. California." Oyez. Accessed November 27, 2019. https://www.oyez.org/cases/1961/554.

case. This form of reasoning, whose origin is found in the ancient traditions of English customs, dictates that that which is necessary cannot be determined to be criminal. Thus, it cannot be a crime to sleep in areas of the public interest if it is the only reasonably available location and there are no other alternatives. Given this development, future legislation which aimed to curb the visibility of the mentally ill of this nature must first ensure that there is, at least one, reasonable alternative, so that no individual would be punished for mental health or poverty. The state of California was compelled to enact homeless shelters via nearby hotels, whose rooms had been purchased as to allow a viable alternative to those on those homeless who so desired one.[7] Still however, this ruling would later prove to be inconsequential in addressing the public concerns towards the homeless at the time; the California statues replacing the formerly unconstitutional one required proof of identity through either a birth certificate or driver's license. These demands were restrictive unnecessarily and, in effect, limited the number of homeless individuals from ever being able to claim their entitlements. Additional, quotas were enacted that further limited the efficacy of any potential shelter. The 1962 *Robinson v. California* decision is one in which the direct influence of English common law can be observed. By applying the common law theory to the specific context of a policy issue, there was an organic growth in American history and jurisprudence.

One legal result of the overall movement to deinstitutionalize resulted in state legislation in California which would go on to serve as a model for the nation in how to enact policy with the intent of minimizing responsibility for the mentally ill while preserving the rights afforded to them. A bipartisan bill in the California State Legislature, the Lanterman–Petris–Short Act (LPS Act) would be signed by Governor Regan in 1967. The LPS Act had several objectives, and in

[7] Robertson, Marjorie J. *Homelessness: A National Perspective*. New York U.a.: Plenum Press, 1992, 313.

effect revolutionized the way in which the legal system impacted the mentally ill in every aspect. The most notable change, and the first objective of the legislation was, "[t]o end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, and to eliminate legal disabilities."[8] There would not simply be a lack of involuntary commitment however, and the LPS Act provisioned how an act of doing so by a law enforcement officer must occur for it to be considered appropriate; by doing so, the LPS Act intended to preserve the rights of individuals.[9] This was outlined in Section 5150 of the LPS Act, which provides three criteria for the involuntary commitment of an individual, that they are: a danger to themselves, a danger to others, or "gravely disabled."[10] For reference, a gravely disabled individual would be one that was determined to be, "unable to provide for his or her basic personal needs for food, clothing, or shelter."[11]

The outline provided here would manifest into what would simply become known as a *5150* by California law enforcement, in that the appropriate standards have been met to consider an individual apt for involuntary commitment. Further, if an involuntary detention were to occur, it would be limited to a 72 hour hold in a psychiatric ward. A further hold, outlined in section 5250 of the LPS Act, would allow for an additional 14-day extension if that individual were still determined to have met any of the three categories. Finally, as outlined in section 5350, if the psychiatrist overseeing the patient determined it fit, he or she would have the ability to withhold the patient under a "Temporary LPS Conservatorship," which would extent to a maximum of 180

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[8] The Lanterman–Petris–Short Act 1967 (CA) 5001
[9] A discussion here is merited on the extent to which involuntary commitment in the name of healthcare constitutes an undue breach of personal liberty. In short, there is no easily digestible response, and courts have struggled with precisely this question.
[10] The Lanterman–Petris–Short Act 1967 (CA) 5150
[11] Conservatorship of Susan T 36 Cal. Rptr. 2d 40, 884 P.2d 988, 8 Cal. 4th 1005 (1994)

days. This three-step system, in which care could be extended in rare circumstances to at most six months was developed to be an alternative to the vague system in place before, which did not see a comparable level of accountability nor respect for patients' rights. However, as will be later examined, this change to how the California legal system interacted with the mentally ill would prove incredibly consequential.

In tracking the relationship of governmental responses to the effects of deinstitutionalization and to the motivations based a reasoning of rights-based protections it helps to understand how many of the legal decisions came to be. Steadfast advocates, particularly the American Civil Liberties Union(ACLU), have consistently stood to preserve the rights of marginalized individuals, possibly to the extent of disservice of the now homeless in the eyes of some health professionals.[12] At multiple instances throughout the late twentieth century did the ACLU file amici curiae, repeatedly with the intention of lowering the rates of involuntary detention. Susan Mizner, Disability Rights Program Director of the National ACLU said, "Conservatorship is the biggest deprivation of civil rights aside from the death penalty."[13] Further, the practice of forced medication was increasingly unpopular and viewed as unnecessary by the general public. The changing perception came to a head when, in 1989, the California State Court of Appeals overruled the prior interpretation of the Lanterman-Petris-Short Act in *Riese v. St. Mary's Hospital and Medical Center*.[14] Rather than permitting healthcare professionals from determining whether forced medications were appropriate, the court held that the consent of the patient must first be attained in nonemergency situations. This case, a class

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[12] Wiener, Jocelyn. "'We've Lost Our Compass." For California's Most Visible Mentally Ill, Is a Return to Forced Treatment a Solution - or a False Promise?" CalMatters, December 30, 2019. https://calmatters.org/projects/mentally-ill-forced-treatment-conservatorship-california-debate/.
[13]Disability Rights Program, ACLU, May 2018. https://sdaction.files.wordpress.com/2019/05/conservatorship-statement-2018-voluntary-services-first.doc.pdf.
[14] Riese v. St. Mary's Hospital and Medical Center, 259 Cal. Rptr. 669, 774 P.2d 698 (1989)

action suit brought in behalf of the plaintiff by the ACLU, shows the influence that the advocacy group has, as well as their effectiveness, in effecting change in medical practice via legal means.

In any historical analysis, especially ones in which the impacts of rhetoric are concerned, it must be established the role rhetoric could or should have, and why that is relevant in the first place. Rhetoric is, in its own right, difficult to define, not yet considering for its historical utilities. On one hand and on the macro level, it can act as a conduit for action, helping to consolidate and push forward societal level shifts in reaction. On the other it can serve to provide subtext to any dialogue. It can even be understood as subjectivity itself. “Democracy is, among other things, a vast argument machine and desire machine, and its most important products are the democratic rhetoric’s, such things as equality, rights, transparency, freedom, and so on.”[15] In this example, it challenges the relationship of democracy and human rights in the using the word of rhetoric. For the purposes of historical analysis however, rhetoric is an excellent tool. It can serve as post markers, highlighting a specific point in time for historians. Further, it can be tracked, upon which its development over time serves as grounds for historical analysis itself. This is how rhetoric intends to be used in this paper, to be tracked and commented upon, so that a timeline may gradually emerge and help to define the understanding of deinstitutionalization.

One notable theory is that the use of rhetorical symbols in political and public discourse is a natural consequence of high-level topics. As comes modernity so too does the complexity of its issues, posits Tom Christiansen. He writes, “One[possibility] is simply that the world is growing more compounded, resulting in more complex political- administrative apparatuses and public policies and producing politicians who are more conscious of how reform symbols can be

[15] Agnew, Lois, Laurie Gries, Zosha Stuckey, Vicki Tolar Burton, Jay Dolmage, Jessica Enoch, Ronald L Jackson, Luming Mao, Malea Powell, Arthur E Walzer, Ralph Cintron, and Victor Vitanza. "Octalog III: The Politics of Historiography in 2010." Rhetoric Review 30, no. 2 (2011): 109-34, 127.

manipulated."[16] This would certainly ring true in any public discussion surrounding deregulation at large which, while reducible to the belief that the government is not the best actor for the public's interest, carries many more implications than the one belief. As a result, the potential of power for symbols in coming to represent rhetoric itself is monumental. Paradigms will inevitably exist of course, but the use of popular rhetorical symbols, like caricatures of the government as a 'nanny state' and of 'welfare queens' are simple and common, easily digestible and able to be understood. Christiansen also note how the spread of how symbolic rhetoric has changed over the past century. "The increased globalization of reform ideas and measures also enhances the symbolic aspect of reforms… Administrative reforms are thus enhanced through the transnational exchange of ideas"[17] The advent of the internet and a global economy has, to a certain extent, established a means and a reason for expanding international communication. This would certainly be the case in any examination between the United States and United Kingdom, particularly if one also considers the historical element of shared political rhetoric. This acceleration of communication has only facilitated the use of symbolic rhetoric, as symbols come to be interpreted in their own ways across cultures, in effect spawning multiple versions of the same core belief.

With this in mind, a careful analysis of the historical research by Jonathan Potter and Fiona Collie gains a subtle understand otherwise possible overlooked. Their research analyzed the efficacy of rhetoric as it pertained to healthcare during the time of deinstitutionalization and the move to community-based care. Their sources are varied and strong, as they looked to past historical and psychological research to establish a hypothesis, and later confirmed it with a study of their own. "Policy[of deinstitutionalization] which for critics in some cases amounts to

[16] Christensen, Tom, and Per Laegreid. "Administrative Reform Policy: The Challenges of Turning Symbols into Practice." Public Organization Review 3, no. 1 (2003): 3, 5.
[17] *Ibid*.

little more than privatization of argue areas of health service, can be represented in the reassuring humanistic imagery of neighborliness, close ties, social support, and a life style more akin to the village the urban housing estate."[18] It is here that a core paradigm is identified, the belief that a community will be more apt and able to care for the ill and disabled. Moreover, it was also established that, when provided with the care of specialty that would be demanded of the community if government run institutions, uniquely capable of handling these specific cases, were to be removed, public opinion shifted little. It may even be ceded that the model for moving to community-based care is not the most effective one, but it represents a chance for the community to try, together. In this sense, in accordance with this paradigm and the framework put forward by Christiansen, it becomes clear that discourse surrounding deinstitutionalization was intentionally modeled so that ordinary people would believe that they could bet on themselves and their communities to effectively handle crises.

Overall, these two papers should demonstrate what purpose rhetoric serves in any historical analysis. In this case, it will be used to showcase the developments of symbols and what that represents. Much of the policy emerging from public debates are predicated on specific paradigms that, for better or worse, come to drive discourse. The rhetorical techniques utilized by the parties involved can be didactic, but they can oftentimes manifest in a change in policy or legal standing, as was the case in multiple instances with deinstitutionalization. In the remainder of the paper, when discussion academic literature, media reports, or anything else, it should be noted that their utility stems mostly from their ability to provide the contemporary narratives; historical analysis in this regard will be slightly historiographical.

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[18] Potter, Jonathan, and Fiona Collie. ""Community Care" as Persuasive Rhetoric: A Study of Discourse." Disability, Handicap and Society 4, no. 1 (1989): 57-64, 62.

One American academic who examined the rhetoric surrounding the homelessness of families, a subset which included mostly women and children as a small but particularly vulnerable group, and evaluated various methods of response, was Judy Flohr. In her study *Transitional Programs for Homeless Women with Children*, she investigated the efficacy of different programs in reducing chronic homelessness. Her study examined programs which could potentially be utilized to address family homelessness in different contexts throughout the nation. Flohr looked to redefine the rhetorical notions surrounding family homelessness. Rather than identify it as the failings and shortcomings of parents, which includes the secondary impacts those decisions had on the children, Flohr looked to ascertain in an empirical method the factors driving the phenomenon. She isolated the following qualities: the majority did not have any life skills (career or interpersonal), most were second generation welfare recipients, and most were becoming parents at a young age.[19] Her study successfully produced a reasonable suggestion for future efforts at addressing homelessness with particular attention towards the mentally ill. The context should be noted here that this is firmly in the era of community-based care, in which the American government has a severely limited role.

Included in the study was a real-world clinical trial, which proved to be most successful at reintegrating different chronically homeless families with transitional programs. She concluded that the optimal length for placement within these rehabilitation programs was 24 months, which guaranteed enough time for the individual to join the workforce and establish a modest savings, identified as a key factor in its ability to enable said individual to withstand a financial emergency; these small crises are often responsible for returning the homed back to the streets. The study further found that additional services provided by a transitional program were

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[19] Flohr, Judy K. *Transitional Programs for Homeless Women with Children: Education, Employment Training, and ... Support Services*. Place of Publication Not Identified: Routledge, 2016, 3.

highly effective at preventing a potential relapse into homelessness. These programs were identified as: child programs, employment training, healthcare, living skills education, permanent housing assistance, and support services. Select transitional programs, in offering these services, were found to be exceptionally capable of decreasing rates of the chronic homeless. Before any large claims can be made, it must be asserted that there exists a large limitation to this study. It is predicated fully on the notion that these services are provided to women and children, who constitute only a small proportion of the total homeless population, and who carry with them a specific set of needs and challenges. Still, the study is remarkable for its ability to isolate risk factors and counter with public policy recommendations.

The qualities listed above in the previous study (lack of life skills, welfare dependent, and a young parent), which were identified as potential markers of an individual at-risk for homelessness, undoubtedly contributed to the perception of the "welfare queen." This is the notion that women, typically minority mothers, were the main culprits in squandering tax funded services. This notion is best explained by S. Stanley Eitzen. In *Paths to Homelessness* he writes,

> Welfare, and particularly welfare mothers, have become America's scapegoat. Placing the blame on welfare recipients, stereotypically defined as irresponsible black women with a horde of kids, produces a polarizing ideology that pits hard-working "us" against "lazy "them."[20]

The above section was written in the 1990s during a period in which welfare reform was an intensely political issue. As Eitzen notes, the issue was presented as a dichotomy, through which Americans were to choose their allegiance, typically along partisan lines. Furthermore, by illustrating 'welfare queens' as irresponsible, they were actively categorized as undeserving of

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[20] Timmer, Doug A., D. Stanley Eitzen, and Kathryn D. Talley. *Paths to Homelessness: Extreme Poverty and the Urban Housing Crisis*. Boulder, CO: Westview, 1994. 56

potential aid and services. This supported conservative rhetorical efforts in their effort to reform welfare and reduce government spending on social services. Unsurprisingly still, it also had the effect of further marginalizing already disadvantaged and underprivileged groups. This rhetoric would later culminate in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, further stifling the social services available.[21] Through weaponizing rhetoric, a conservative agenda was successful at implementing its ideals for a more restrictive allocation of funds.

In order to properly evaluate how the rhetoric of deinstitutionalization was interpreted at the time, it must first be understood how mental illness was talked about, common perceptions, and its role in the media, as well as the role of the media itself. In navigating existing literature on the topic of deinstitutionalization, it may be necessary to widen the scope of historical review to include other forms of academic papers, namely those in psychology. As will be demonstrated, psychology research papers assist in the process to illustrate what prevailing contemporary thoughts were and are fundamental in establishing a timeline. Although they are not intended to supplant historiographical review, their inclusion should be considered necessary. Still, although they can assist in the formation of a timeline with regards to rhetoric within academia, it would be beneficial to examine them only in the context of other prospective media, like the role of broadcast media as being both determinative and representative of public sentiments on the topic.

Prior to the 1963 Community Mental Health Act, which in effect began the precursory stages to deinstitutionalization, the notion of homelessness differed greatly. Initially, the perception at the time through the 1950s can be wholly construed as one of mainly old men

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[21] Cammisa, Anne Marie. *From Rhetoric to Reform?: Welfare Policy in American Politics*. Boulder, CO: Westview Press, 1998.

living on skid rows.[22] The belief was one that the destitute simply lacked the fortitude to withstand society, and thus chose a differently, less respectable lifestyle. This contrasted greatly with the 'new homeless' that emerged following the closing of mental institutions. Instead, this group was markedly younger, more likely to include members of minority groups, suffered from greater poverty, and often struggled with access to sleeping quarters, if any were available in the first place. This shift in demographics, more than serving as a representation of how the changing legal framework and support systems favor certain demographics, helps to explain why the responses towards the problems that resulted from deinstitutionalization, namely homelessness, differed from earlier responses to the societal problem.

It should be qualified that although the link between deinstitutionalization and homelessness is not unconditional. While the cause of increased levels of homelessness is oftentimes associated with the decline of mental institutions, there exists discourse on exactly the extent deinstitutionalization played. The prevailing school of thought is that it was not deinstitutionalization itself per se, but rather the manner of its execution that exasperated the problem of homelessness among at risk populations. There are various components to this. First, the lack of planning at the time to institute a system of structured living arrangements severely limited the potential for those who could not rely on family or community care to stay off of the streets. This had the consequence of leading to more interaction between the criminal justice apparatus and the mentally ill, in what has come to be known as a 'revolving door' of incarceration and release for the mentally ill. Jack Tsai writes, "A cycle of homelessness and incarceration, particularly among people with mental illness or addiction problems, has been

[22] Rossi, P. H. The old homeless and the new homelessness in historical perspective. American Psychologist, 45(8). https://doi.org/10.1037/0003-066X.45.8.954. 1990, 954-959.

observed among the general U.S. population."[23] The argument is presupposed by the idea that any interaction with the criminal justice system, and particularly those that result in some sort of charge, actively harm the potential of that individual to reacclimate to society and engage in a stable lifestyle.[24] A further consideration to be made is the correlation between race and both incarceration rates and felony convictions, which disproportionately affect minority groups, thereby increasing the overall risk that members of these groups fall into the 'revolving door.'[25] The confounding factor of race merits additional examination, especially in the context different time periods through American history.

In the context of mental institutions and the effect that race plays as determinative, Judith Mishne notes how there existed two similar views, theoretically diametric but similar in effect, limited the utility of mental health treatment in the 1970s.[26] The first is that by following an intense race conscious model, potential treatment for patients of color were oftentimes generalized into existing stereotypes, usually not conducive to rehabilitation. Similarly, taking a race blind approach resulted in clinicians sometimes overlooking cultural nuances within specific racial groups, and failing to consider certain behavior as abnormal. This struggle to properly account for race and how to approach it reflects the struggles of clinicians dealing with the fallout of deinstitutionalization in the 1970s. This will be later reexamined after evaluating the notions of race during the times of institutionalization.

In addition to the changes and trends in psychotherapy historical literature and that became more clear during the 1970s, there also existed a shift in legal reasoning which, along

[23] Tsai, Jack. *Homelessness among U.S. Veterans: Critical Perspectives*. Oxford: Oxford University Press, 2019, 111.
[24]Pew Center on the States, State of Recidivism: The Revolving Door of America's Prisons (Washington, DC: The Pew Charitable Trusts) 2011.
[25] Shannon, S.K.S., Uggen, C., Schnittker, J. et al. The Growth, Scope, and Spatial Distribution of People With Felony Records in the United States, 1948–2010. Demography 54, 1795–1818 (2017). https://doi.org/10.1007/s13524-017-0611-1
[26] Mishne, Judith. *Multiculturalism and the Therapeutic Process*. New York: The Guilford Press, 2002, 15

with the changes as evidenced by the previous cases[in Installment I], further help to refine the timeline that exists as it pertains to deinstitutionalization. Although the prior cases aim to establish the organic growth in American jurisprudence that accompanies the byproducts of deinstitutionalization, the following cases aim to demonstrate the shift in legal rights within the client-patient dynamic. This carries with it the implications of treatment itself and serves to illustrate how changing methods were driven by developments in legal reasoning. These cases can, as a whole, demonstrate that legal mechanisms worked in tandem with changing public opinion and an overall shift in values to promote a focus of deinstitutionalization.

Any analysis in the legal developments regarding mental institutions in this era must first begin with *Tarasoff v. The Regents of the University of California*, which in 1976 redefined existing standards and established a precedent that would be later referred to in future cases. The plaintiffs in *Tarasoff* filed suit against the University of California after their daughter was murdered by a graduate student, Prosenjit Poddar. During therapy sessions with a school psychologist, Poddar admitted that he intended to murder Tarasoff. The psychologist moved to have him civilly committed, which he was for a short while, but was released shortly thereafter, after demonstrating lucidity and a rational state of mind. The psychologist was instructed by his supervisors to not subject Poddar to additional detention. Following the return of Tarasoff from a vacation, Poddar followed through with the threat and killed her. Neither her nor her parents were alerted to the threat, nor did local law enforcement receive any such information.

The court held in favor of the plaintiffs and established a consequential opinion that has been confirmed through decisions in other jurisdictions. The essential rule is that a mental health professional has the duty to protect not only the patient, but also any individual who specifically threatens a patient. This carried far reaching implications, importantly in what it did not assign as

a duty of mental health professionals. By limiting the responsibility to one of harm to others, there established a standard by which mental health professionals had no right to further confine or restrict the patient, outside of normal procedures, for the potential to harm their self. While it also instituted a common practice of warning the threatened individuals, and at times law enforcement depending on the severity of the threat, the standard set by *Tarasoff* drastically affected future cases regarding the rights and duties of mental health professionals in their decision to institutionalize individuals.

The effect of *Tarasoff* is at once apparent. One other 1976 case decided on the state level found a hospital liable for the suicide of one of its patients claiming that there was sufficient evidence to assume that the individual held suicidal tendencies.[27] However, in later cases, such as *Bellah v. Greenson* in 1977, it becomes clear that there is a shift in the nature of the doctor-patient relationship. Invoking the *Tarasoff* standard, the court held that the psychiatrist could not be held liable for the suicide of one of his patients since the patient exhibited thoughts of harm exhibited only to their self, thereby circumventing the necessary condition of exhibiting desire for harm against a specific individual, other than themselves, and thus never activating the duty for the psychiatrist to breach their confidentiality.[28] This being the first major case to apply the standards of *Tarasoff*, the ability for mental health professionals to effectively detain and confine mentally ill individuals, who show potential for harm only to themselves and no others, was sharply curtailed. This specific view of liability would be affirmed in a later case.[29] In effect the rights of patients as it pertains to confidentiality increased substantially.

Whether one views it as the potential to withhold patients became even more limited or rather increased liberties to not be withheld, the circumstances by which patients could be

[27] *Eady v. Alter*, 51 A.D.2d 991 (N.Y. App. Div. 1976)
[28] *Bellah v. Greenson*, 81 Cal. App. 3d 618 (1977)
[29] *Oringer v. Rotkin*, 162 A.D.2d 113 (N.Y. App. Div. 1990)

forcefully held become even more narrow in 1987. In *Currie v. United States*, the court held that mental health professionals could, in theory, engage in errors in commitment decisions if it can be determined that the mental health professional did so with good faith and thoroughness.[30] This discretion afforded to the professionals was arguably proper in allowing patients to be individually treated and without the at times burden of necessary holds, but regardless it made it even more likely that an individual with mental health issues of any sort could be granted release from an institution.

This shift in approach in legal understanding was confirmed through many later cases. In 1980, *Shaw v. Glickman*, a dramatic case with a Hollywood flair, the court found in favor of the defendants, claiming that they were not negligent for failing to restrain an individual, who could have been predictably angry after during divorce proceedings but made no discernable threat to any specific individual.[31] Another case, *Doyle v. United States of America* was similar in nature, but related to public institutions via the United States Army. Following the killing of a security guard by a former member of the Army after he was discharged, the affected family filed suit. Due partially to the nuances of Louisiana law, which are subject to precedent in a different many than all other American states, but standard of *Tarasoff* was not invoked, but the effects remained the same. There was no obligation by the Army Hospital to hospitalize the individual, as there were no *specific* threats made other than a general desire to kill. As such, it was not a duty to hospitalize, nor a duty to warn.

However, this concept of mandated warnings should be qualified, as the rule would be later redefined in 1983, when another case established that public institutions would be mandated to warn of imminent threats. This action was not required by private relationships between

[30] *Currie v. United States* (Currie II), 836 F.2d 209, 210-11 (4th Cir. 1987).
[31] Shaw v. Glickman, 45 Md. App. 718 (1980)

patients and their doctors.[32] IN a manner reminiscent of *Tarasoff*, by limiting directives through strict discernment, it, in effect, authorized that which was not limited. This clarification, while providing that public institutions warn others to the threat of any harm, be it by that individual to themselves or others, it effectively solidified the notion that a mental health therapist need not report or warn of any imminent danger, if the threat were not specified. In reference to this case, psychologist Mary Moline writes, "… in California the clinician in private practice has no duty to warn about potential suicide. However, there is a legal duty to take reasonable steps to prevent a threatened suicide. In a public agency, however, the clinician *must* warn about potential suicide."[33] Written for mental health professionals in training, this encapsulates the contemporary notions of legality surround ding the institutionalization of patients and the extent to which the professionals and restrict their movement through confinement. It enshrines the culmination of developments in American jurisprudence at the time and enables practitioners to effect that change in practice.

The period of refinement regarding the legal understanding and enforcement as such continued to develop through the 1980s. In the 1983 case of *Chrite v. United States of America*, a Veterans Affairs hospital was scrutinized for its release of a patient following the threat he made about a specific individual. Although such a threat was documented, the patient was later released, and would go on to kill the threatened individual. The court held that the release was proper and did not account to negligence as there was no issued recommendation to again institutionalize the patient. The hospital was considered negligent however, in its lack of forewarning to the threatened individual.[34] The decision for a hospital or mental health

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[32] *Johnson v. County of Los Angeles*, 143 Cal. App. 3d 299 (1983)
[33] Moline, Mary E, George Taylor Williams, and Kenneth M Austin. n.d. *Documenting Psychotherapy*. Thousand Oaks: Sage Publications, Inc., 80.
[34] *Chrite v. United States*, 564 F. Supp. 341 (E.D. Mich. 1983)

professional to not institutionalize in light of an immediate threat poses ethical questions but remains a route in certain scenarios.

Having now examined the overall trends regarding perception in academic as well as legal contexts, it would be appropriate to examine how that these notions are reflected in popular media and determine the extent to which the very notions that surround deinstitutionalization percolate up from popular perceptions. This can be observed through various media, all of which will combine to illuminate a path of paranoia that begin to afflict the general American population with regards to the mentally ill. Whether it be through broadcast media via cinematic and theatrical releases, print media, or simply rhetoric employed when speaking on the issue, public opinion, first the support and the later backlash of deinstitutionalization can be tracked, and a timeline established.

With regards to broadcast media, one need only turn to film to see the shifting sentiments held by the American public on the issue of deinstitutionalization. Assuming that one is willing accept, or even consider, broadcast entertainment as being even somewhat representative of societal shifts, it becomes evident that the film industry was able to focus in on prevailing anxieties of the time.[35] This can be seen first with movies suspicious of institutions and was later countered with the rise of the horror genre.

One film highly indicative of the general growing unease with institutionalization in the first place was *One Flew Over the Cuckoo's Nest*. Released in 1975, the movie follow's the story of Randle Patrick McMurphy, an individual who feigns insanity in order to avoid a sentence of hard labor. Although he figured that opting into a mental institution would result in an easier time spent, he is quick to discover the difficulties that accompany being a patient there. He seeks to

[35] Arias, Eric. "How Does Media Influence Social Norms? Experimental Evidence on the Role of Common Knowledge." Political Science Research and Methods 7, no. 3 (2019). 561-578. doi: 10.1017/psrm.2018.

disrupt a ward routine that he so obviously opposes, much to the dismay of Nurse Ratched, the primary antagonist throughout the film. The film presents characters who suffer from multiple mental illnesses, from the epileptics in the case of Jim Sefelt and Bruce Fredrickson, the developmentally disabled with Charlie Cheswick, Max Taber, and Martini, the mute “Chief" Bromden, to the paranoid Dale Harding. Filmed shortly after the process of deinstitutionalization began to gain momentum, this film was the first introduction for many Americans into the occurrences and happenings of a mental institution. The film is based on the 1962 novel written by Ken Kesey and evokes the time period roughly similar to the beginning of deinstitutionalization. Throughout the film, the mental institution as a concept is consistently portrayed as this negative entity, disarming patients of their rights and civil liberties while making them pawns to the whims of the staff, particularly Nurse Ratched. There was an underlying sense that the innocence of the patients was being abused by the power hungry and dominant staff, who wielded power for the sake of control. To say that the film is a stark endorsement of any system other than a mental institution would be an understatement.

Whether the film was shaped by a rising tide in public opinion against mental institutions or, more likely, the film influenced the beliefs of many, it is clear that the film fundamentally changed the way that rhetoric was used when talking about mental health.[36] This can almost be attributed largely to the finale of the movie, in which the main character undergoes a lobotomy and loses all sense of self. The death of the main character in what can only be described as a mercy killing highlights the insidious nature of it all. In reference to the film M. Anderson writes, “A study involving 146 college students revealed that considerable negative changes in attitude had occurred following the screening of the film, yet there were no changes after the

[36] Domino, G. Impact of the film, “One Flew Over the Cuckoo's Nest, on attitudes towards mental illness.” *Psychological Reports, 53*(1), https://doi.org/10.2466/pr0.1983.53.1.179. 1983, 179-182.

students had viewed a television documentary. Films of this nature may well have a considerable influence on the way we see things, but this can only be due to the focus on the individual's health and subsequent problems."[37] As a result, the general American public grew to become more skittish at the prospects of an unconsented detention, medication, and treatment.

The tone of the *One Flew Over the Cuckoo's Nest* becomes especially defined when compared with the rise of the horror genre which followed in the decades to come. Whereas the former shows the patients of the institution, and the mentally ill at large, as sympathetic and passive in nature, horror films looked to exasperate anxieties that existed surrounding the potential for violence that then came to be associated with the mental instability. Although its exact origin is muddled, the genre began to rise in popularity in the late 1970s and did not reach its height until the 1990s. Horror films consistently portrayed the antagonists in the genre as mentally ill. The grotesque nature of the films seeks to elicit fear for entertainment, and typically followed a plot whereby the antagonist suffers from some unknown mental illness and pursues the protagonists, usually with the intent to kill. Although exact origins of the genre are impossible to pin down, as horror fiction has always existed within literature, there is a consensus that the 1960 horror film *Psycho*, at the very least, had an outsized impact in kickstarting the rise in popularity for the genre.

The plot of Psycho revolves around the antagonist, Norman Bates, who exhibits signs of dissociative identity disorder. Although there is nothing irregular about the character in the first half of the film, the audience soon learns that he adopted his mother's personality after killing her. To be clear, this is not to suggest that *Psycho* spawned the horror genre, but the sheer popularity of the movie resulted in increased awareness in the psychopathology in the public

[37] Anderson M. Journal of Psychiatric and Mental Health Nursing, "One flew over the psychiatric unit': mental illness and the media." 2003, 297-306.

sphere.[38] In analyzing the extent to which the trials of Norman Bates can be considered reflective of the overall anxieties of society, M. Anderson writes, "Psycho (1960) pushes forward his experience of psychopathology in the form of a split personality with terrifying effect. We also see the impact of society on one individual (Norman Bates); this is the most powerful message."[39] It again becomes clear broadcast media can have an active role in shaping the perceptions of issues surrounding various topics. In the case of *Psycho*, the fear that mental instability could lead to thrilling scenarios of violence can help to explain the rise of the subsequent horror genre.

The notion of horror as both determinative and representative of public sentiment is one that can assist in honing the overall timeline. In examining the role of popular culture, Anthony Carlton Cooke noted how, "public desire for the containment of mentally ill persons through their identification and subsequent distancing from society, was sustained for the most part by collaboration between the mental health and judicial systems through appeals to "public safety," whether on ethical, legal, social, or medical grounds. With the invention of the 'psychopath,' the common goals between psychiatry and criminal justice became even more pronounced…" [40] The relationship between media, policy, legal precedent, and human effects is all related, influencing the others over time.

All of this is to say that a timeline emerges when examining the relationship between deinstitutionalization and the general American public. In chronological order, the oscillating public over time becomes noticeable. Although it would be much more contestable to claim that

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[38] Mondal S. (2019) One Grey Wall and One Grey Tower: The Bates World in Alfred Hitchcock's *Psycho*. In: Flynn S., Mackay A. (eds) Surveillance, Architecture and Control. Palgrave Macmillan, Cham, 2019.
[39] Anderson M.Journal of Psychiatric and Mental Health Nursing10, 297–306'One flew over the psychiatric unit': mental illness and the media, 2003, 299.
[40] Cooke, Anthony Carlton. n.d. *Moral Panics, Mental Illness Stigma, And The Deinstitutionalization Movement In American Popular Culture*. Springer International, 165.

the origins of deinstitutionalization were the result of changing public perception, it is with great confidence that one could claim that the process heavily affected general opinion. Films like *One Flew Over the Cuckoo's Nest* served almost an explanatory role to the policies which were just beginning at the time in portraying mental institutions as a uniquely negative space that deprived individuals of their rights and helped to sway public support towards deinstitutionalization. Academic reviews of the topic furthered public discourse especially in the print media, and the developments in values percolated into the legal system at later dates, enshrining in jurisprudence the shifts in perception on the topic. A slight resurgence of sentiments against the mentally ill could be possible posited, if one were to consider the prospects that the horror genre, which expanded in popularity following deinstitutionalization, had some sort of indirect relationship with it. It is in this context that the effect of rhetoric can be most effectively tracked and studied.

Although the origins of the process of deinstitutionalization are not precise, with some in the academic community believing that it began in the 1950s and other believing the 1970s, it can certainly be said that the mechanisms for change truly came about the result of post-World War II reforms that fundamentally changed how health was considered. In using returning veterans in particular, but with implications for the mentally ill in general, the postwar reforms can be stated as the genesis of the eventual process of deinstitutionalization.

A discussion of the history of deinstitutionalization would be prudent to include definitions of the various waves which might have had unique characteristics and altered how responses were initiated and explain the contemporary context of those responses. Sociologist Duane F. Stroman looked to provide discernment regard the different waves of deinstitutionalization, defined by the effects. Later the waves of policy will be discussed, as they

too are the result of specific aims, and while their waves correlate roughly to the eventual waves of deinstitutionalization, the couplings are not precise. The first wave, which does not tightly fit into the policy-based timeline outlined below began in the 1950s, and looked to depopulate institutions of persons with 'mental illness,' as Stroman defines in the narrow sense, leaving those with developmental disabilities to remain.[41] By no means was this exhaustive, and a diverse population remained. Still, the argument here is meaningful in how it would shape the overall population towards one that was heavy towards those with developmental disabilities, which held greater potential to be viewed as sympathetic in later the public eye and later informal examinations of the mental health institution within the media. As will be examined later, the advent of psychotherapeutic drugs may have allowed those with mental illnesses, as defined by Stroman, to live seemingly normal lives in the public with limited supervision. The second wave meanwhile, Stroman argued, would be much more impactful because with it came the more consequential antecedents of deinstitutionalization. The second wave facilitated the transition for those with developmental disabilities, for whom psychotherapeutic drugs held much less promising and whose supervision was much more taxing for healthcare workers. It is through these two waves that context can be understood regarding how and why the predicate policies were enacted.

The postwar changes manifest themselves in a mix of ways. In terms of policies and political implications, it is difficult to overlook the creation of the National Institute of Mental Health (NIMH). Following an expose published in *Life* magazine in 1946 which highlighted the at times dim reality within mental health institutions, calls for Congressional action to further commit to biomedical and health related research became mainstream and it soon became

[41] Stroman, Duane (2003). *The Disability Rights Movement: From Deinstitutionalization to Self-determination.* University Press of America, 122.

imperative to pass meaningful legislation.[42] This resulted in the National Mental Health Act of 1946, which aimed to assuage some of the complaints made about institutions, namely by returning veterans and their families, whose support for change expedited the process politically.[43] Further aided in how the problem was addressed in nature as tied to returning veterans were the testimonies of psychiatrists, namely Robert Felix. Felix, who was then the Director of Public Health Services (PHS) Division of Mental Hygiene, pushed the fundamental point that early detection and treatment can improve the efficacy of mental health assessments while also improving military morale, a vital consideration as the United States was beginning its shift into Cold War policies.[44] Additionally, Felix argued, mental health services could only help veterans returning from war in reintegrating back into civilian life, and could have potential indirect effects not easily observed. By successfully arguing for its creation, Robert Felix was named Director of the NIMH and saw through its expansion into the 1960s.

The creation of the NIMH is impactful because of how its realigned efforts within the United States to examine the problem of mental health itself. Rather than permitting states to determine their own policies, as had largely been the case prior, the development of the NIMH redirected the financing of research and treatment from a state level to the federal level. [45] The act, via its fundamental restructuring of research, enabled more expansive efforts to examine the field of mental health, which while nascent and limited largely to returning veterans for political purposes, was an essential part of laying the groundwork for future change to be affected regarding deinstitutionalization.

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[42] Stroman, Duane (2003*). The Disability Rights Movement: From Deinstitutionalization to Self-determination.* University Press of America, 176.
[43] Herman, Ellen (1995). *"The National Mental Health Act of 1946". The Romance of American Psychology: Political Culture in the Age of Experts*. Berkeley: University of California Press. pp. 246–250.
[44] *Ibid.*
[45] *"NIMH (National Institute of Mental Health)". Espionage Information: Encyclopedia of Espionage, Intelligence, and Security.*

Another potential contributing factor not to be ignored in the initial transitory wave of patients from institutions to other forms of treatment was due to psychotherapeutic drugs. As argued by Duane Stroman, the advent of psyc3hotherapeutic drugs enabled those with severe mental illness to be considered as potential transfers to a less intensive form of care; by introducing these drugs which would oftentimes calm the individual and make them less prone to violent outbursts, the threat of violence was reduced and it became possible to consider alternatives from the specialized healthcare professionals working in mental institutions. [46]

The next phase of deinstitutionalization, relating to the later similar yet distinct reevaluation of the mentally ill and developmentally disabled is not necessarily a phase at all, despite many in academia claiming it to be so. Rather, it is more appropriate to label it as the continuation of earlier instituted policies, such as the creation of the NIMH that ultimately led to the production of data and new approaches. Unsurprisingly given the context, the efforts through the 1950s reflected largely the overall concern relating to returning veterans and their mental health. Due largely to the Korean War at the time, Congressional action was once again mobilized, this time resulting in the formation of The Mental Health Study Act of 1955 which looked to provide, “"an objective, thorough, nationwide analysis and reevaluation of the human and economic problems of mental health."[47]As seen here, the central mission of this legislation was to determine possible routers forward, to enable the government to produce information and then decide on a path forward. It is not correct, as is commonly asserted in historical literature, to claim there are distinct phases of deinstitutionalization, because the there is a lack of discontinuity. Rather, there was a shifting of objectives, as prevailing attitudes were coming

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[46] *Stroman, Duane (2003). The Disability Rights Movement: From Deinstitutionalization to Self-determination.* University Press of America, 132.
[47] U.S. Department of Health and Human Services, *National Institute of Mental Health (NIMH)* https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh.

under challenge, and thus causing a 'lull' in legislative action. The report produced by the commission would later be published in 1961 and, under the stewardship of President Kennedy, would help to form the foundation of the 1963 Community Mental Health Act.

Still, insofar as it relates to the American development of mental health institutions and regardless of any notion of phases, it can be stated decidingly that President Kennedy and his policies ushered in the mechanisms which permitted the eventual full movement of deinstitutionalization. This particular attention can be at least partially attributed to the personal connection that President Kennedy had to mental illness and developmental disabilities, since his younger sister Rosemary Kennedy had undergone a failed lobotomy which left her permanently incapacitated and with incoherent speech. Although the official account is that the lobotomy was intended to address very specific mental disorders, more likely did Joseph Kennedy, the father of Rosemary and John F. Kennedy, order the lobotomy in an attempt to curb the behavior of his daughter as to prevent her from potentially ruining the image and brand of the politically ubiquitous Kennedy family.[48] Since the lobotomy effectively placed Rosemary Kennedy in a vegetative state, regardless of the original intention it is unambiguous that President Kennedy had a very close connection to mental health institutions.

The actual implementation of the Community Mental Health Act of 1963(CMHA) was a mixed bag of results. Put under the domain of the NIMH, there was to be a shift from institutions to more community care centers. This was never realized on the ambitious scale the legislation had proposed. Through a series of roadblocks, full implementation was never realized. For example, less than half of all proposed community centers were ever built, and of those that

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[48] *Gordon, "'Rosemary: The Hidden Kennedy Daughter,' by Kate Clifford Larson". The New York Times, Meryl* (October 6, 2015).

were, exactly zero ever received full funding. [49] Perhaps unsurprisingly, this had a chilling effect on the efficacy of local institutions to retain staff and rehabilitate patients. Then, despite a lack of available beds the result of a failed implementation, state hospitals began to reduce the amount of beds, with the decline stabilizing at only 10% of the pre-CMHA bed count.[50] Although perhaps well meaning, the rollout of deinstitutionalizing policies were poorly implemented by failing to prepare adequately for the burdens that would be adopted by local communities which may not have the resources or skillsets sufficient to address the incoming populations. Many of the formerly institutionalized would struggle under community care and an increasing amount of this population was forced into homelessness as a result of lack of access to mental health services.[51] This problem, created directly as the result of government handling of the initial transitionary period marks a fundamental shift in how mental illness would go on to be treated in the United States, as national level decision making would come to have little effect once patients were outside of the scope of direct care.

The final acts of Congressional legislation of this time period which helped to usher in an era in which deinstitutionalization became possible arrived were those relating to the welfare state and its reforms through the 1960s. In 1965, President Johnson signed into law two amendments to the Social Security Act of 1935, effectively creating a national health insurance for individuals over the age of 65 and an insurance program for individuals at or near the financial level of receiving federal aid, Medicare and Medicaid respectively. It should be noted that through the 1960s there was an overall reduction of poverty, mostly the result of Social Security reforms, as mentioned above, and the uptick of equity via an increase in federal funding

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[49] Michelle R. Smith, "50 years later, Kennedy's vision for mental health not realized," *The Seattle Times*, October 20, 2013.
[50] *Ibid.*
[51] Michael B. Friedman, "On Deinstitutionalization; Better Care for the Mentally Ill," *The New York Times*, September 24, 1986.

for federal housing programs.[52] By this process, it is possible that the true side effects of deinstitutionalization, most prevalent and visible when occurring concurrently with high rates of poverty, were effectively countered. This theory holds merit in the sense that it could help to explain why despite the process of deinstitutionalization beginning in the 1960s many of the effects, and subsequent responses to those effects, were not realized until more than a decade later into the late 1970s and 1980s, when the poverty rate began to again increase. [53] This theory is certainly susceptible to counterarguments, namely the fact that any legislation aiming to address the fallouts of deinstitutionalization was done not because of increased effects but rather changing perceptions in common culture. This idea will be explained elsewhere. Regardless, by reducing poverty greatly alongside the period of time that state hospitals effectively pushed out their patients, the efficacy of the movement at large could have been prematurely declared successful.

With the American model for deinstitutionalization, it can be advantageous to look to other models and note how similar issues were addressed and the extent that the comparison can be useful at all. Perhaps the best system to compare would be the British model, which underwent its own period of deinstitutionalization during roughly the same time period. This parallel offers the opportunity to exact how nuances are expressed, whether it be through the differing political systems (although still largely comparable) or different in culture percolating into differing approaches towards the mentally ill. It can be helpful to compare how similar nations went about solving similar problems in distinct fashions.

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[52] Dylan Matthews, "Poverty in the 50 years since 'The Other America,' in Five Charts," *The Washington Post*, July 11, 2012.
[53] Ashley Edwards, "Poverty Rate at 12.3 Percent, Down From 14.8 in 2014," *United States Census Bureau*, September 12, 2018.

The story of mental health institutions in the United Kingdom follows that of the American narrative but diverges at a few key points. Similar to the United States, the United Kingdom also experienced a revival of public support for the mentally ill following the end of World War II, as returning veterans and their reintegration into society marked one of the primary goals of the post war British governments.[54] For reference however, the increase in attention paid to mental health can be attributed to the overall increase of politization of healthcare during the time period, which ultimately resulted in the formation of the National Health Service in 1948. Incorporated into this new model for healthcare were the Victorian era mental institutions, now state run with the goal of providing without regard for ability to provide payment. However, this model, while popular, was faced some levels of opposition by the economically liberal Conservative Party. An increased level of scrutiny resumed under the next Conservative government, led by Winston Churchill in his return to Prime Minister, which resulted in the Enquiry into the Cost of the National Health Service, also known as the Guillebaud Report. This report aimed to examine the long term overall costs that could be associated with a national health insurance program; while no major cuts were recommended, there was a suggestion that there be additional funding for community based care, with a pretense on the notion that it would be more economically feasible to sustain than under a national model, where costs had risen more rapidly than anticipated.[55] The Report ensured that NHS would survive in its current form and offered potential routes for tweaking policy relating to the mentally ill.

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[54] *Chester, T. E. (June 1956). "The Guillebaud Report". Public Administration. 34 (2): 199–210.*

[55] Powell M. “Exploring 70 years of the British National Health Service through Anniversary”. Int J Health Policy Manag. 2018, 7.

Decades later in the 1980s a similar story followed. A Conservative government under PM Margaret Thatcher, wary and concerned about the continued growth of the healthcare costs, invited Roy Griffiths to produce a report on the state of the NHS. A former director of Monsanto Europe and a director and later deputy chairman of Sainsbury's (a supermarket chain in the United Kingdom), Griffiths was expected to examine the nature of the NHS with an eye towards capital and the private industry. The final Griffith report concluded with the assertion that a move to community care, and a relegation of responsible by the NHS, would be both economical and more effective for the mentally ill. It made recommendations that there be created a position, the Minister of State for Community Care, to oversee a successful transition while stressing the importance of empowering local authorities in two ways. The first was to ensure that local social services were equipped to deal with long term and continuing care for those transitioning. Local healthcare, however, would adopt responsibility for acute and primary care. By diving the responsibilities in this fashion, Griffiths very clearly defined the roles that the various departments of government would hold.[56] In doing so, by empowering local authorities but providing a role for an overall policy czar, the Griffiths Report would enable the British government to reduce overall spending while forming an accountable system for deinstitutionalization prior to the actual movement. The Health Foundation's report on community care in the 21st century in the UK described how the Griffiths Report, "… highlighted the fragmentation and lack of [prior] coordination in community care provision."[57] This is one possible explanation as to why the later process of moving the mentally ill out of the hospitals

[56] Wing, J. K. "Community Care: Agenda for Action. A Report to the Secretary of State for Social Services. By Sir Roy Griffiths. London: HMSO. 1988. *Bulletin of the Royal College of Psychiatrists* 12, no. 8 (1988), 346–47.
[57] Ben Gerschlick et al. "Provision of community care: who, what, how much?," *The Health Foundation Briefing* (April 2017).

and institutions was not as problematic as it was for the Americans, who had more clearly defined struggles in doing so but also lacked a similar approach to transition.

The final chapter of substantive change for the British healthcare as it relates to the mentally ill came in the form of a 1989 white paper, 'Caring for People,' which was the direct inspiration for the National Health Service and Community Care Act of 1990. This act is what would split the responsibilities between the NHS and 'providers,' which would become NHS trusts, competing with one another. This formalized the transition of the state into a role of 'enabling' mental healthcare services, rather than administering it directly through the NHS. One addition furthered support for healthcare workers and the development of practical support.[58] This more or less aids in demonstrating that the ultimate implementation of policy in the UK focused mainly on the potential good for local care in the form of individual connections between the mentally ill and healthcare workers, even if in their own community.

The reasoning for deinstitutionalization in the United Kingdom, while similar to the American underlying rights-based argument, added an economical component not clearly observed in arguments across the Atlantic. Repeatedly, through the initial report Guillebaud Report, the Griffiths Report, and finally the 1989 white paper "Caring for People," it becomes clear that there existed in British discourse surrounding deinstitutionalization an element of economic weighing and feasibility that was inexplicitly not as large as a part of the American conservation at this point in time. While some speculations may exists attempting to explain why this is so, considering such theories including an American aversion to federal government and its institutions(in the governmental sense), it remains that within the rhetoric most effective in

[58] National Health Service and Community Care Act 1990 (UK)

the United Kingdom in favor of deinstitutionalization was economical in part whereas largely rights-based in the United States.

The argument shifts here to how it is to be determined what is best for a homeless individual. Advocates for the homeless mostly advocate for a maximum sense of personal liberty, freedom from detention if homelessness if the only crime, and an overall belief of first addressing the overall causes of homelessness in contemporary society prior to the criminalizing of the homeless themselves. In the current context generally, and in California specifically, there are linguistical shifts which reflect the changing rhetoric surrounding the causes of homelessness. This is unmistakable in the growing debate on the state level surrounding housing policy and zoning laws. YIMBY(Yes-in-my-backyard) and NIMBY(No-in-my-backyard) have entered the lexicon for the state politicos. Respectively, these two acronyms are used to describe one's position towards development. The words do not quite qualify as a disparaging term, but they are oftentimes used to slander those of the opposite belief. The prototypical YIMBY supports urbanization with dense development and a decrease in the amount of R1 zoning, which reserves land development for single family dwellings only. In effect, this group opposes suburbanization and the sprawl which has become so endemic to California. The YIMBY movement, although contributing largely towards a single goal of urbanization, has a complicated base of support within the state. The Millennial generation is faced with unprecedented housing prices, with relatively stagnant wage growth, resulting in declining rates of real estate holdings, particularly in urban, job-laden areas.[59] Although there is discourse within the movement the extent to which affordable housing and rent control should be considered as

[59] William A.V. Clark. "Millennials in the Housing Market: The Transition to Ownership in Challenging Contexts, Housing, Theory and Society," 36:2, 2019, 206-227.

policy goals along with urbanization, there is a general subscription to the belief that an increase in the supply of housing will result in a decrease in housing prices.

The prototypical NIMBY is more difficult to ascertain. By and large the movement aims to preserve the suburban character of a neighborhood, emphasizing the lifestyle afforded by suburbia.[60] Yet, the base of support here is much more diverse. In the failure of SB50, a California State legislative bill which would have transferred control of zoning from local communities to the state and was accepted to have allowed for a dramatic increase in housing stock, unlikely alliances were formed to defeat the bill. There includes opposition from suburban communities, neighborhood groups, and somewhat unexpectedly activist organizations from both working- and upper-class communities. [61] While affluent communities aimed to avoid development and growth, working class communities viewed development as a harbinger of gentrification and the dissolution of the community.

This dichotomy is important in the context of deinstitutionalization because of the efforts by YIMBY activists to reframe the debate surrounding homelessness. Although their policy proposals relate to housing, they are successful demonstrating that high housing prices in California are contributing to the overall growth of the homeless population within the state. By so doing so, they have effectively managed to affect the rhetoric used and, though maintaining a sympathetic view towards the homeless, elucidates the notion of policy failure bearing responsibility for homelessness, increasingly designated as a public health hazard.[62] At least

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[60] Brown, Greg, and Hunter Glanz. "Identifying Potential NIMBY and YIMBY Effects in General Land Use Planning and Zoning." *Applied Geography* 99 (October 2018): 1–11.
[61] Dillon, Liam. "The revenge of the suburbs: Why California's effort to build more in single-family-home neighborhoods failed." *The Los Angeles Times*. May 22, 2019.
[62] *National Law Ctr. on Homelessness & Poverty, No Safe Place: The Criminalization of Homelessness in US Cities*. February 2019.

within the confines of California politics, the YIMBY movement has realigned the rhetoric utilized surrounding the homeless.

With an eye towards future developments in deinstitutionalization, it would be mindful to note how states react to the recent *Martin v. City of Boise*. Originally decided in 2018 before a panel of three judges from the 9th Circuit Court of Appeals, *Martin* redefined the extent local governments were able to address the problem of homelessness. Although filed originally against the city of Boise, Idaho, the decision has already proved incredibly consequential for the California local governments. *Martin* established that the 8th Amendment of the US constitution, protecting against cruel and unusual punishments, precluded the enforcement of local ordinances which prevent outdoor sleeping in public areas if there were no shelter beds available. This decision has in effect decriminalized homelessness, especially for major metropolitan areas within the 9th Circuit's domain on the west coast. This does not mean that there simply be available shelter beds, as rarely are a community shelters at 100% capacity on any given night, but rather that there be sufficient beds for ever homeless individual.[63] In the decision, Judge Berzon writes, "So, even if we credit the City's evidence that BRM's facilities have never been "full," and that the City has never cited any person under the ordinances who could not obtain shelter "due to a lack of shelter capacity," there remains a genuine issue of material fact as to whether homeless individuals in Boise run a credible risk of being issued a citation on a night when Sanctuary is full … If so, then as a practical matter, no shelter is available."[64] The court here clearly finds that it would be a violation if one were to be punished for situational circumstances which are not under the discretion of the individual.

[63] Martin v. City of Boise 920 F.3d 584 (9th Cir. 2019)
[64] *Ibid.*

While this decision was lauded by civil rights groups who saw it as one step towards the ending of criminalization of poverty, mental health, and any other of the contributing factors towards homelessness, *Martin* is not without its issues. It now presents a much higher standard for cities to meet before turning to enforcement of local ordinances, such as laws against sleeping outdoors or on public property.

With the Supreme Court refusing to hear an appeal of *Martin v. City of Boise*, the case is unlikely to be overturned in the near future. It has become a de facto statement on the failures of dealing with the ramification's deinstitutionalization, in which communities now scramble to add homeless shelters to provide healthcare services for the mentally ill. An analysis of the case in the Harvard Law Review states, "Finally, by challenging the City in a forum where they had some control over their stories, the plaintiffs spurred media coverage that questioned the City's policies, highlighted the lack of shelter beds, and, generally, reframed their struggles as city-wide concerns."[65] As the rise of the homeless crisis rises to the forefront the public attention, higher levels of scrutiny of local governments and the efficacy of their responses should be expected.

So why was the American experience with deinstitutionalization so markedly different? Although one could suppose that motivating factors, originating in public rhetoric and manifesting in public policy, should not play a large role in the eventual consequences of similar policy results, in this case the reasoning for doing so is incredibly consequential. Harry Richard Lamb, Professor Emeritus of USC School of Medicine, asserted that most of the eventual fallout from deinstitutionalization in the United States was the result not from the act of transition but rather from the manner in which its implementation was carried out, to differing degrees of

[65] "Ninth Circuit Refuses to Reconsider Invalidation of Ordinances Completely Banning Sleeping and Camping in Public." *Harvard Law Review* 133 (December 2019): 699–706.

success, in hundreds of communities throughout the nation.[66] In his reasoning, some of the largest factors causing the disruption not measured in other nations experiencing similar changes is the lack of continuity of care, in that simply changing the locus of healthcare did not, in itself, prove to be effective in providing for long term care. I would argue further.

The United States did not effectively plan for the process of deinstitutionalization to the extent that they could have in a multitude of ways. Although there were various governmental boards, panels, groups, and organizations of the sort established to oversee different aspects, there were simply much too many for there to have been effective coordination and implementation of policy recommendations. Despite the existence of such leaders, like Robert Felix, the Director of Public Health Services, there was no single administrator who could have seen through, or at least planned, effectively. What was delegated in the British model would have been split between four offices in the American government, the Departments of: Health and Human Services, Housing and Urban Development, Education, and Veterans Affairs. Further, the legal system of the United States held unique contributions in how it shaped the development of deinstitutionalization. While policy recommendations and Congressional legislation did lay the groundwork for deinstitutionalization, much of the substantive changes were much more sudden and in the form of court decisions. The effect here is that it prompted more reactionary measures from governments, local, state, and federal, the direct result with being presented with a change not yet anticipated.[67] The consequence of this is that deinstitutionalization, shaped largely by the public rhetoric within the United States, was difficult to properly account for in forward looking policies. There also exists the legal culture in which mental illness, whether it be in the form of developmental disabilities or otherwise, was

[66] Lamb, Harry. (1984). *Deinstitutionalization and the Homeless Mentally Ill. Hospital & community psychiatry*. 899-907.
[67] Please refer to earlier sections for legal analysis

oftentimes criminalized to the extent that, when combined with the exploding prison population during the same period, led to a systemic disorder by which the mentally ill and their criminal history actively discouraged rehabilitation.

It is unlikely that the problem of homelessness will improve of its on accords. Necessary to addressing the issue is a thorough understanding of the failures of deinstitutionalization and its ongoing effects on homeless populations in the United States. The moral imperative presented continues to loom large and grows too with the severity of the homeless epidemic. Changes in culture, the predicate for meaningful and lasting change in legislative and judicial action should be paramount. As the problem grows, a successful model may yet emerge that can demonstrate efficacy in effecting permanent change in a manner consistent with American values.