The Cost of Cutting Corners:

Long Term Impacts of Deinstitutionalization in Connecticut

Nora Holmes

AP Research

Hall High School

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Abstract:

The deinstitutionalization movement was implemented on a large scale in Connecticut, with four closures occurring out of a planned six. While deinstitutionalization has been marketed as a way to give mentally ill patients more individualized community based care (CBC), pre-existing research indicates that it was not implemented effectively in the short term and as a result, discharged patients often face unemployment, homelessness, or incarceration. However, no pre-existing research exists on how deinstitutionalization has played out in the long term. This leads to the research question “What are the long term impacts of deinstitutionalization in Connecticut?” Seven mental health experts were interviewed on how they have implemented CBC in County X, formerly home to a major mental health hospital. Data was then coded for perceived successes, perceived failures, and emotions related to the closure. It was found that creation of in-demand programs as well as the closure of an inhumane institution were perceived as successes while a lack of political will, finances, and demographic challenges associated with the mentally ill population led to deinstitutionalization’s failure. Stress, pain, and resentment were associated with the closure. Limitations and implications are discussed.

Chapter 1: Introduction

As mental health (MH) has become more visible in recent decades, treatment is becoming less stigmatized (Shahwan et. al, 2020). Research indicates that this change is the result of advances in psychology, allowing a better understanding of complex disorders (eg. schizophrenia) in addition to advances in drug therapy. The combination of these two factors, especially the introduction of antipsychotics like Thorazine in the mid 1900’s led to the discharge of patients who had previously been confined to long hospital stays (Krieg, 2001). Through psychological advances, drug therapy, and the desire of state governments to reduce state spending, the deinstitutionalization movement gained widespread support as a more humanitarian and cost efficient way to treat mental illnesses (Chaimowitz, 2019).

Deinstitutionalization is defined as "...a shift in the care of mentally ill (MI) persons from long-term psychiatric hospitalization to more independent living environments," as well as community based care (Krieg, 2001, p. 356). Community based care (CBC) is characterized by community living, whether this be in group homes or alone with the availability of appropriate counselling, medications, case management, and housing services. While an increase in personal freedom is seen as more desirable to patients, Quanbeck, Frye, and Altshuler (2003) credit the movement with the loss of thousands of hospital beds. This loss has led to an increase in policing and homelessness of the MI as they no longer have a safe place to receive treatment (Chaimowitz, 2012). In turn, Cunningham and Vigen (2002) present that once the MI are in custody, they are disproportionately represented on death row.

Chapter 2: Review of the Literature

Overview

Little research exists on the long term impacts of deinstitutionalization, as the movement peaked about thirty years ago. Since then, there has been little to no follow up in politics or research. Additionally, no research has been conducted on the movement's implementation in Connecticut which is important when considering that the state closed four hospitals with original plans to close six. Broadly speaking, research indicates a need to investigate if the short term consequences of deinstitutionalization are also long term as well as the way that this has played out in Connecticut, a state which wholeheartedly embraced deinstitutionalization.

Homelessness

One of the largest themes emerging from preexisting research is an increase in homelessness following hospital closure. Krieg (2001) found through a broad and in depth content analysis that closures associated with deinstitutionalization can lead to homelessness; Even if individuals are able to find housing, the loneliness of living alone can exacerbate symptoms, ultimately leading to readmittance or

homelessness (Krieg, 2001). Teplin (1990) supported these findings, discovering from their interviews and survey of local inmates that homelessness increases when hospitals are closed, as MH symptoms can make it harder to hold down a job and thus pay necessary bills (Teplin, 2009). This homelessness leads to increased contact with the criminal justice system, as many residents have a “not in my backyard” (ie. NIMBY) perspective and turn to law enforcement to preserve an “idyllic” town atmosphere, creating a pattern of increased contact between the MI and the criminal justice system.

Incarceration

Consequently, the shrinking network of mental hospitals across America is accompanied by the growth of the American prison system, with the American incarceration rate being five times that of what it was in 1977 (Sugie & Turney, 2017). This is important when noting that Quanbeck et al. (2003) found that America’s expanding prison system coincides with a loss of hospital beds and a rise in law enforcement disproportionately targeting MI individuals. The situation is especially problematic when considering MI prisoners are overly represented in death row populations when they were previously directed to MH facilities. Cunningham and Vigen (2002) cite multiple studies in their meta analysis, showing that roughly 16.2% of inmates on death row were observed to have symptoms of a mental illness, a percentage which is not reflective of the general population’s concentration of MI individuals.

Even if MI individuals are able to avoid incarceration, many face what is known as “the revolving-door syndrome,” which is frequently experienced by those with chronic mental illnesses and occurs when patients are constantly being discharged and readmitted to mental healthcare facilities (Quanbeck et. al, 2003). Quanbeck et. al (2003) noticed this trend in their narrative study of a man they refer to as “Mr. B". After years of admittance and discharge from hospital care for Bipolar Disorder, he was eventually incarcerated and his access to medication was revoked (2003). Mr. B was living in a region where the closure of one California hospital and consequential discharge of MI inpatients was followed by a 300% increase in the MI prison population (Quanbeck et. al, 2003). This increase indicates

that formerly hospitalized patients were unable to maintain stability following discharge and subsequently entered the criminal justice system, suggesting that CBC was not provided following hospital closure.

Further harming the MI population are the conditions within prisons. Solitary confinement cells are often only six by nine feet with limited exercise, privacy, and family contact while regimentation, harassment, and staff monitoring are increased (Cunningham & Vigen, 2002). Additionally, solitary confinement, whether used for rehabilitation as it was intended earlier or punishment as it was intended later, has devastating impacts on MH; it can lead to feelings of helplessness, defeat, anger, and emotional emptiness (Cunningham & Vigen, 2002). As Porter and DeMarco (2019) presented, this incarceration can worsen MH symptoms and exacerbate the conditions which led to their incarceration (Porter & Demarco, 2019).

In this case, prisons become a self fulfilling prophecy (Henry, 2020). The MI are criminalized due to MH episodes or their symptoms lead to situations such as homelessness which they are criminalized for, leading to their incarceration, and worsening their mental state. Furthermore, their cognitive ability declines as they age while serving long term sentences (Colambert & Pennequin, 2020).

Ethical considerations

The connections between mental illnesses not being addressed professionally and the resulting over-policing and overrepresentation of the MI on death row demonstrates a need to evaluate whether or not the deinstitutionalization goal has been realized in the communities which have followed this approach. Since the deinstitutionalization movement was relatively recent, taking place from roughly 1950 to 1990, little research has been done on the long term effectiveness of the movement or the factors impacting a region’s ability to deinstitutionalize. Thus, it is unclear whether the trends seen in previous research are case specific or can be applied across regions and to the current timeframe.

Deinstitutionalization in Connecticut

Laws and executions of deinstitutionalization differentiate across states in accordance with party politics, geography, and social/socioeconomic factors specific to that region. In Connecticut, the deinstitutionalization movement was most active from roughly 1990-2010. During this period, three major mental hospitals were closed; Attempts to close an additional two were cancelled after resident protest. When it became clear that town residents and MH advocates were uneasy about the release of hundreds of patients into the community, the “Keep the Promise” movement was raised to pressure Connecticut legislature into implementing, finding, and staffing the necessary number of CBC options.

However, there has been little follow up research to see whether or not the promise has been kept in Connecticut and, if it has, to what extent. This study seeks to examine whether or not Connecticut has effectively implemented CBC following its closure of multiple state hospitals.

Chapter 3: Research design and methodology

To understand the effectiveness of CBC after the closure of state hospitals, a semi-structured interview-based research method was implemented. The study’s data is qualitative. The interviews were extremely in depth, ranging from 20 to 45 minutes depending on the openness of the participant and the fluidity of the conversation.

Regional selection

Given that support for the movement peaked about 40 years ago, in the late 1970s and early 1980s, with the hospital closures occuring in the last 10-30 years, research focuses on interviewing MH experts in County X of Connecticut, which had a recent (1996) closure of a major mental hospital (Hospital N). County X was selected for the date and reason for its closure; 1996 was at the tail end of the deinstitutionalization movement, thus ensuring that the timeframe is in accordance with the broader trend. Additionally, reporting during the closure indicated that the main reason for closure was a desire to save

money and the wishes of MH advocates to find more humane treatment options for the mentally ill (Rhinelander, 1981).

This local reporting established that County X utilized deinstitutionalization. Formerly, Hospital N contained 8,000 beds, indicating that it was major and omnipresent enough to create opinions and reactions in the eyes of community members (*The Hartford Courant*, 1992). Additionally, 1996 is also recent enough to contain living memory of the area pre and post closure, allowing for comparison in data coding, yet far enough in the past to observe the long term impacts of deinstitutionalization.

Interviewee selection

In accordance with Osborn's (2002) findings that American mental healthcare providers were dissatisfied with the implementation of CBC, it was determined that MH experts would give unique and intimate insights into the long term impacts of deinstitutionalization and its implementation in County X. Thus, case workers, social workers, and community MH advocates/leaders (further referred to as MH workers) were interviewed to give a deeper look at the needs and problems in each town from the perspective of a professional with direct knowledge of the field and matters of interest. Furthermore, their knowledge of the MI community and those who are experiencing deinstitutionalization first-hand was utilized in a snowball sampling approach, an interviewing technique in which the initial subjects direct the researcher to a next line of subjects and so on (Creswell, 2007). Snowball sampling also worked well with the semi-structured interview process as it gave participants the chance to recommend another interviewee organically. This process used preexisting dynamics between experts in communities and gave a better perspective on what programs are most prevalent in the community as often, multiple subjects would refer the researcher to the same organization.

Semi Structured interviews

Interviews themselves were semi-structured, with baseline questions to direct respondents. A total of seven interviews were conducted with the questions serving as loose parameters to facilitate a thematic

discussion (Appendix A). Some initial debate occurred on how to characterize the study and whether or not it was appropriate to approach the issue from the point of a needs-based assessment. However, after reviewing existing research, particularly the work of Quanbeck et. al (2003), it became clear that there was a need to not just narrate what was happening in County X, but also to examine why certain trends were occurring and what resources were needed to prevent the phenomenon from continuing. The study of Henry (2020) proved exceptionally helpful in this regard. The researcher used open ended interview and survey questions to determine what factors had led to prisoner incarceration (Henry, 2020). The results were used to determine what preexisting social and socioeconomic factors had led to incarceration as well as evaluate what programs had been effective in remedying these factors (Henry, 2020). By letting participants have an active role in narrating their story instead of confinement to rigidly structured interviews, the researcher was able to gain a deeper perspective on what most prominently impacted the participant, which, in turn, allowed them to better see the needs of the population and any potential solutions (Henry, 2020).

In the current study, to protect participant confidentiality, all interviewees are referenced by pseudonyms.

Data Analysis

Once transcribed, the seven interviews were roughly 12-17 pages long and thus, extensively coded for emotions, perceived successes, and perceived failures related to the closure. This was done in accordance with Leedy and Ormrod's (2016) qualitative coding process, which recommended organizing data into preliminary categories, dividing the data into meaningful units, and defining each code as specifically as possible (Leedy & Ormrod, 2016). This process can be seen in Appendix B.

The study was modeled after that of Plowman et. al (2007), in which the researchers conducted interviews similar in length and structure to this study. (Plowman et. al, 2007). Following interviews with MH workers, narrative accounts were created to organize the longitudinal data. Next, each sentence was analyzed and sorted into three themes which were triangulated for accuracy. This was done in alignment

with the research question. To reflect alignment throughout the entire research process, interview questions were created to align with three key concepts: Effectiveness of implementing CBC, efforts being made to improve the quality of CBC, and accessibility of these programs to an often disadvantaged population (Table 1). Once data was collected, it was analyzed first for major emerging themes in accordance with the methodology of Plowman et. al (2007) and, after certain themes emerged, coded for emotions of interviewees, perceived successes, and perceived failures of the movement in County X.

Table 1: Interview question thematic alignment

Theme	*Number*	*Question*
Effectiveness of CBC implementation	2.1	Would you say there is an adequate/appropriate ratio of MH professionals to those in need of their services in your area?
	2.2	What community MH resources are available in your area?
	2.21	How would you rate participation in these programs?
	2.5	Would you say the MH need has been met in your area?
	2.6	Would you say that there are enough programs in your area?
	3.2	Have you noticed an increase in homelessness after the closure of the institution?
Efforts currently being made to benefit area	2.4	What efforts has your area made to make these programs well known and destigmatized?
	3.3	What is being done to make these programs more well known/accessible to those in need?
Current program accessibility	2.3	How many of these programs would you say are covered by Medicare/Medicaid?
	2.4	What efforts has your area made to make these programs well known and destigmatized?
	3.1	What barriers, if any, do you think prevent those in your community from getting access to CBC?
	3.3.1	What would you say the barriers to raising awareness and treating clients are?

Chapter 4: Presentation and discussion of the findings

Overall, participants reported dissatisfaction with the results of the deinstitutionalization movement. Although they believed in its power to be effective and to help those who had previously been facing long term institutionalization, they cited multiple factors which had impacted the movement's effectiveness and ultimately harmed the region. Among these were lack of investment in the community, particularly

the failure of Connecticut to reinvest the 36 million dollars[1] saved by closing Hospital N. Other obstacles cited were limited community discussion and peer support for the MI, lack of public transportation and affordable housing for clients, and lack of political will to improve the situation.

Part A: Emotional responses related to hospital closure

Participants reported negative emotions in association with the hospital closure (Table 2). This was attributed to distress about the state of community mental healthcare, personal pain associated with the hospital closure, or professional stress and the feeling of being overwhelmed by the large need (Appendix B).

Table 2: Emotional responses of Connecticut MH experts to hospital closure

Code	*Emotion*	*Definition*
1e.	Stress	Feeling of stress, being overwhelmed with the increased demand for their services which was accompanied by a decrease in financial resources.
2e.	Resignation	Resignation, helplessness when faced with a demand they believe will never be met
3e.	Pain	Personal pain related to the closure of the hospital and its negative impacts on their community
4e.	Anger, resentment	Frustration with the current state of affairs, resentment towards the state for perceived apathetic behavior to calls for help

Stress, resignation

Alyssa stated that "...I feel very overwhelmed by the amount because while I give therapy, and I do outpatient services, and caseload is upwards of 30 people which is a lot." Teresa, Christopher, Alyssa, Lily and Gordon all reported an increased demand for MH services following the closure of Hospital N, with Gordon reporting a 28% increase in demand with a 25% decrease in funding. Kim agreed with this, stating "You're asking people to do more with less." This trend was seen across the board and at Teresa's organization, it has led to "...a lot more staff turnover as we go through time." This turnover has

[1] Thirty-six million dollars is the number most commonly cited by the MH experts but this could not be found in state budget reports.

increased stress on individuals in the organization, as they have to spend time and resources lobbying with Connecticut's Nonprofit Alliance for funding while also coping with a rotating cast of staff.

Kim and Alyssa both expressed the sentiment that the need for MH services will never be met, indicating both stress and resignation about the high demand, with Alyssa stating "You know, it seems like no matter how big the programs get, there's always more people who need more things. And at first we were noticing at my job like it was basically people who were discharged from [Hospital N]. But as time went on, we were seeing younger and younger people who had MH concerns coming in."

Pain

Catherine and Christopher connected the closure of Hospital N to personal and regional pain, with Christopher observing that "...there's pain on personal and the town level." Catherine's mother was discharged from Hospital N without the facility contacting the family; The pain of Catherine's experience surrounding Hospital N is what ultimately led her to her work as an advocate for MH and the creation of peer lead solutions and other forms of CBC. Pain was attributed to personal loss, communal unemployment, and Alyssa reported the sense of the town "dying" which was traced by other participants to empty businesses, poverty, and unemployment resulting from the closure of Hospital N, once County X's largest employer. This demonstrates intersectional negative emotions of stress, pain, and anger.

Anger, resentment

Lily and Alyssa felt anger surrounding the execution of the Hospital N closure, asserting that the state had not been responsive to their pleas for more funding for CBC programs. Lily summarized this sentiment, adding that vast sums of money had been expended for COVID-19 relief but none had been available when MH experts requested funding to improve CBC and meet the increased demand for their services. Alyssa adds to this, stating "There's just not enough money. They don't put nearly enough finances into things…It's not a problem until something like Sandy Hook happens and then you get a national spotlight...Most people don't want to know about mental health until something nasty happens

and then then they're asking what happened." Thus, interviews indicate that lack of funding and the perceived betrayal of the state's broken promises has contributed to MH expert anger and resentment.

Part B: Perceived successes

All participants believed that the programs made available by their organizations had some success in treating the MI in their communities (Table 3).

Table 3: Perceived Successes of Deinstitutionalization according to Connecticut MH experts

Code	*Success*	*Definition*
1s.	Creation of utilized programs	Creation of programs which are widely utilized within the community. This can be indicated through organizational data, MH expert opinions, and the presence of waiting lists
2s.	Accessibility	Creation of programs which are available, affordable, destigmatized, and easy to get access to
3s.	Closure of an inhumane institution	Belief that Hospital N was inhumane in its treatment practices and its closure allowed patients to seek more beneficial options (ie, peer support groups, CBC, clubhouses, etc)

Creation of in-demand programs

Teresa, Alyssa, and Gordon all stated that the programs of their organizations were popular and often had waiting lists. These programs included, but were not limited to, clubhouses, case management, therapy, housing assistance, transitional processes to aid discharge, career services, and outpatient treatment. However, these programs had extensive waiting lists which could indicate that the MH need was not being met.

Accessibility

Alyssa, Teresa, Gordon, and Lily, all MH providers, said that their programs were available at no cost, with them being covered by medicare/medicaid or grant funding. Kim, Catherine, and Christopher were

classified as MH advocates (ex: lawyer for those fighting civil commitment) as opposed to providers but they maintained their services were accessible.

Closure of an inhumane institution

Catherine and Kim both saw Hospital N as an inhumane and ineffective MH facility, with Catherine describing the current MH system as a "...very carceral system, very power driven. It's ripe for very bad things to happen to people." Kim furthers this, asserting that the hospitals under current civil commitment law[2] are places where patient rights are violated through involuntary medication, forced commitment, and seclusion practices, all of which undermine overall faith in the MH system. Existing research on the practices of Connecticut mental hospitals validates this, finding that Hospital N was used as part of the eugenics movement to forcibly sterilize patients[3] (Laebner, 2012). Thus, the closure of Hospital N and similar hospitals across the state can be seen as a victory for the MI. However, Catherine asserted that since limited peer led groups and other forms of CBC had been created, Connecticut has essentially traded one institution (hospitals) for others (shelters and prisons).

Part C: Perceived shortcomings

Overall, participants reported dissatisfaction with the results of deinstitutionalization. Lily, Catherine, Christopher, Alyssa, Gordon, and Teresa all stated they did not think the MH need had been met in their area, although their reasons for believing this differed (Table 4).

Table 4: Perceived Failures of Deinstitutionalization according to Connecticut MH experts

Code	*Failure*	*Definition*
1f.	Lack of resources	Lack of funding promised following the 1996 closure of Hospital N

[2] Current civil commitment law allows involuntary commitment of those with psychiatric disabilities and who are "dangerous to self or others or gravely disabled…" (Office of Legislative Research, 2013, p. 1). Patients who are admitted involuntarily must receive a clinical review once per year and a full hearing every two years (Office of Legislative Research, 2013).

[3] A total of 557 mentally ill individuals were sterilized between 1909 and 1963 in Hospital N and one other Connecticut MH facility (Kaelber, 2012).

2f.	Demographic Challenges	The difficulties associated with working with the MI population can make it difficult to pursue treatment options with them
3f.	State politics	Flaws in state policy have damaged the ability of MH workers to improve the quality of CBC

Lack of resources

The biggest shortcoming in Connecticut's implementation of CBC listed among participants was a lack of funding, particularly the state's failure to reinvest the 36 million dollars saved with the closure of Hospital N back into the community and CBC. There was confusion among participants about where this money ended up. Gordon stated that the money had not gone back into the general fund and was unaware of where it had ended up. Catherine thought differently, stating the money had gone back into the general fund against the community's wishes. The confusion around this indicates that Connecticut not only neglected to communicate its plans with the money, but also failed to communicate with mental healthcare providers, not keeping the promise of ensuring CBC in areas like County X with recent hospital closures.

This lack of funding and investment has led to more barriers in giving CBC to patients. Namely, the lack of affordable housing and reliable public transportation in County X have harmed patients as they have limited their ability to establish "normal" lives following institution closure; This is due to the fact that they're unable to find affordable places to live have no transportation to to locations where CBC is offered according to Teresa and Alyssa.

This lack of funding has, in part, contributed to the emotional distress reported by the experts. Participant Teresa described that the lack of funding provided by Connecticut makes it hard for organizations to retain their staff: "It can be really hard for people who work for private nonprofits or for-profits to keep their staff because we don't get salary increases…The staff we have are very committed to the clients and the mission but sometimes have to make the decision like 'this is perfect and I really love this and believe in what I'm doing, but I have to feed my family so I have to start working somewhere else'." This turnover means less stability for clients due to a rotating cast of therapists and

case workers while also putting more stress on the organization as they are continually having to hire new workers. Alyssa, Lily, Teresa, Kim and Gordon all mentioned lack of financial resources as a barrier to providing effective CBC at their respective organizations.

Demographic challenges

Christopher identified the unique challenges of the MI as one barrier to treating clients, as they can be unable to self report and advocate their needs. This, according to Lily, means organizations have to reach out to the populations instead of the populations reaching out to them. Presumably, this process takes up extra time and resources. Teresa came to a similar conclusion; “We work for people who… might not… want to come out, you know, it's hard to stay in a waiting room if you have anxiety or if you're having you know… psychosis, it can be really difficult to get to a place and get services.”

Additionally, some clients have criminal records due to their symptoms and thus, shelters will not take them. To make matters worse, to keep their benefits which finance medications and treatment, their income must remain under a certain threshold. This systemic poverty and homelessness requires patients to choose between medications and shelter in a region known for its bitterly cold winters. Alyssa described an annual ceremony in the town center for the homeless who’ve died during the year due to exposure, indicating that homeless deaths by exposure are common enough to be present in town thought.

State Politics

Kim describes state political policy as one reason that CBC has not been implemented effectively, pointing out that there is no time length on civil commitment law in Connecticut. This means that individuals can be held in hospitals for a full year before they are eligible for a clinical review, undermining the deinstitutionalization process which emphasizes individual freedom versus institutionalization.

Separately, Lily identified political will as another barrier to the MI being able to receive CBC. Other interviewees identified similar obstacles, with Gordon asserting that the main reason one

Connecticut town was able to get Connecticut to invest in CBC after hospital closure was constituents lobbying their representatives. Alyssa explains that MH is forgotten if it is not advocated for, and the political situation described by Lily and Gordon reflects this.

Kim also discussed the ineffectiveness of Connecticut's seemingly endless task forces on CBC and MH, stating that "Connecticut loves a task force..." but the majority of these commissions have reached similar findings with little follow up action or policy change.

Chapter 5: Conclusions and Implications

Previous research demonstrates that deinstitutionalization has had mixed short term impacts on its communities, with some researchers finding a positive one (Kunitoh, 2013) and some finding negative impacts (Osborn, 2009). In the long term, however, the impact as seen by Connecticut MH experts has been overwhelmingly negative, leading to an increased regional poverty as increased stress and pressures on mental healthcare providers.

Conclusions

In the eyes of community social workers, mental healthcare workers, and MH advocates, the deinstitutionalization movement has not benefited the community in the ways it intended to. The negative emotions (pain, stress, anger/resentment) surrounding the hospital closure indicate that the movement has taken a mental toll on CBC providers as they face new demands and pressures for their services. To answer the research question, the long term impacts of deinstitutionalization are very similar to the short term ones. Closure of an MH facility leads to increased homelessness and an increased demand for services that is often not met due to varying factors and, at large, the MH need is not met. While there have been some successes in providing CBC following the closure of Hospital N, lack of funding, demographic challenges, and state policy have made it harder to provide this care at an adequate level to meet community demand.

This closure resulted in the perception that County X and the town where hospital N was located "dying." Residents of these areas are visibly tired and the closure of businesses, increased residential and commercial vacancies, and rising homelessness are now characteristics of an area that is trying, yet failing in the eyes of participants to revitalize.

Connecticut's failure to reinvest funds saved from the closure of Hospital N is a critical factor in the long term failure of the deinstitutionalization movement and suggests that Connecticut has failed to "Keep the Promise." Although this study focused primarily on one country, the fact that interviewees pointed to problems at the state level indicates that the problems facing County X (Eg: homelessness, underfunding, and lack of public transportation and affordable housing) may also be observed across Connecticut. If this is the case, serious changes in policy will need to occur for both medical and ethical reasons.

Limitations

Due to participant demographics, there are some limitations to the findings. As only a professional opinion has been gathered, there is still no recent perspective of patients on the deinstitutionalization movement. Additionally, the findings from this study can only be applied to Connecticut as the policies and executions of deinstitutionalization However, since this study is the first to investigate within this timeframe and thus serves to determine if further research needs to be done. If a pioneer study within the timeframe was successful, no further research would need to be conducted. However, this study serves the purpose of indicating that further research should be done.

Implications

From an ethical standpoint, the study finds clear implications. Namely, that an increased burden has been placed on MH providers and that this burden is pushing them past a fair threshold and into one where they are facing negative emotions from the stressors of their jobs. In terms of how this impacts clients and those with an MH need, the loss of the hospital has not benefited or harmed them according to

MH experts. While the hospitals did not always treat clients humanely, their closure has resulted in increased homelessness for MI patients and difficulty in getting access to MH services according to MH experts. Thus, the general consensus is that hospital closures exchanged one problem (inhumane facilities) for others (homelessness, systemic poverty).

The major issue listed by participants was the systematic failure to implement CBC and other programs that would help prevent homelessness and destitution among the MI. The “Keep the Promise" movement and local newspaper coverage at the time indicated that the Commissioner’s intentions, on behalf of the state, were “...providing the clinical services each patient requires… He wants to assure close supervision of former patients already in the community as well as those who will be discharged” (*The Hartford Courant,* 1992, p. C14). Advocates and legislators at this time were also calling for hospital closures for humane reasons and thus, the hospitals were closed. However, Connecticut has, through its defunding and long term neglect of areas that formerly hosted mental hospitals, made its true motives known. It is clear through political and economic neglect that Connecticut’s primary cause for hospital closure was reducing strain on the state budget and not patient welfare as was promised. Connecticut’s mistakes need to be addressed through public apologies and efforts to reinvest in the communities that have been abandoned.

Recommendations

Policy

Some challenges listed by the MH experts, such as demographic challenges of working with a MI population that is by definition hard to reach and connect with, cannot be systematically addressed. The problems relating to state polity, politics, and funding, however, are flaws in the political system and seeing the distress they’ve caused County X, should be remedied on the legislative level. Particular attention should be given to reinvesting in CBC as promised, as well as creating programs that make it easier for the MI to be able to afford apartments and access transportation to care centers.

Immediate steps should be taken to alleviate the described problems. In the past, Connecticut's MH task forces have been commissioned and then the findings have been ignored. This pattern needs to end if the current situation is to be alleviated. The expansion of CBC is not just a matter of ethics, but of life and death at this point if more deaths by exposure, suicide, and violently MI patients are to be prevented.

First, the 36 million dollars that went into the general fund should be reallocated to County X's public MH providers (private practices typically bill insurance and thus do not need access to state funding). This would help reduce staff turnover, expand staffing, and create more programs/expand existing ones, thus decrease MH worker stress. Additionally, this money should be directed to provide more affordable housing to get the MI off of the streets and away from shelters where conditions might trigger symptoms.

Connecticut also needs to help County X revitalize through investment in local infrastructure such as public transportation to make it easier for those without cars to get to jobs they might not otherwise be able to reach. This will also make inter-county travel more accessible which could increase tourism and commercial investment in the region.

Future research

Future research should investigate if the same trend has been seen at the regional and national level. Deinstitutionalization was an extremely popular movement and has been implemented across state and regional lines with little follow up to assess its long term effectiveness.

Additionally, future research should investigate what specific factors impact an area's ability to deinstitutionalize. If findings indicated that certain regions were better able to deinstitutionalize due to pre-existing factors, future closure failures could be anticipated and thus prevented. Additionally, this would allow experts to know what characteristics make a region eligible to deinstitutionalize without fear of CBC failure in either the short or the long term and help with the creation of a more effective and standardized national model.

Chapter 6: References and Appendices

References

Chaimowitz, G. (2012). The Criminalization of People With Mental Illness. *Canadian Journal of Psychiatry*, *57*(2), 129.

Combalbert, N., & Pennequin, V. (2020). L'effet de l'âge et de la durée d'incarcération sur la santé mentale des détenus âgés = Effect of age and time spent in prison on the mental health of elderly prisoners. *Annales Médico-Psychologiques, 178*(3), 264–270. https://doi-org.ezproxy.lib.uconn.edu/10.1016/j.amp.2018.06.013

Cunningham, M. D., & Vigen, M. P. (2002). Death row inmate characteristics, adjustment, and confinement: a critical review of the literature. *Behavioral Sciences & the Law*, *20*(1/2), 191–210. https://doi-org.ezproxy.lib.uconn.edu/10.1002/bsl.473

Henry, B. F. (2020). Adverse experiences, mental health, and substance use disorders as social determinants of incarceration. Journal of Community Psychology, 48(3), 744–762. https://doi-org.ezproxy.lib.uconn.edu/10.1002/jcop.22289

Kaelber, L. (2012, November). Eugenics: Compulsory sterilization in 50 American states. University of Vermont. Retrieved May 19, 2021, from http://www.uvm.edu/~lkaelber/eugenics/

Krieg, R. G. (2001). An interdisciplinary look at the deinstitutionalization of the mentally ill. *Social Science Journal*, *38*(3), 367. https://doi-org.ezproxy.lib.uconn.edu/10.1016/S0362-3319(01)00136-7

Kunitoh, N. (2013). From hospital to the community: The influence of deinstitutionalization on discharged long-stay psychiatric patients. *Psychiatry & Clinical Neurosciences*, *67*(6), 384–396. https://doi-org.ezproxy.lib.uconn.edu/10.1111/pcn.12071

Leedy, P. D., & Ormrod, J. E. (2016). Practical research: Planning and design (Eleventh ed.). Pearson.

Office of Legislative Research, Concise summary of civil commitment laws, A. 2013-2013-R-0087, at 1-2 (Conn. Jan. 28, 2013).

Osborn, L. A. (2009). From Beauty to Despair: The Rise and Fall of the American State Mental Hospital. Psychiatric Quarterly, 80(4), 219–231. https://doi-org.ezproxy.lib.uconn.edu/10.1007/s11126-009-9109-3

Plowman, D. A., Solansky, S., Beck, T. E., Baker, L., Kulkarni, M., & Travis, D. V. (2007). The role of leadership in emergent, self-organization. *The Leadership Quarterly*, *18*(4), 341-356. https://doi.org/10.1016/j.leaqua.2007.04.004

Porter, L. C., & DeMarco, L. M. (2019). Beyond the dichotomy: Incarceration dosage and mental health*. *Criminology*, *57*(1), 136–156. https://doi-org.ezproxy.lib.uconn.edu/10.1111/1745-9125.12199

Quanbeck, C., Frye, M., & Altshuler, L. (2003). Mania and the law in California: Understanding the criminalization of the mentally Ill. *American Journal of Psychiatry*, *160*(7), 1245-1250. https://doi.org/10.1176/appi.ajp.160.7.1245

Rhinelander, D. H. (1969 Sep 06). Fairfield Hills Hospital Probe To Be Conducted By Experts. The Hartford Courant (1923-1994), 6.

Shahwan, S., Lau, J. H., Goh, C. M. J., Ong, W. J., Tan, G. T. H., Kwok, K. W., Samari, E., Lee, Y. Y., Teh, W. L., Seet, V., Chang, S., Chong, S. A., & Subramaniam, M. (2020). The potential impact of an anti-stigma intervention on mental health help-seeking attitudes among university students. *BMC Psychiatry*, *20*(1), NA.

Should mental hospitals be closed? (1992, May 7). *The Hartford Courant*, Editorials, C14.

Sugie, N. F., & Turney, K. (2017). Beyond Incarceration: Criminal Justice Contact and Mental Health. *American Sociological Review*, *82*(4), 719–743. https://doi-org.ezproxy.lib.uconn.edu/10.1177/0003122417713188

Teplin, L. A. (1990). The prevalence of severe mental disorder among male urban jail detainees: Comparison with the epidemiologic catchment area program. *The American Journal of Public Health*, *80*(6), 663-670. https://ajph.aphapublications.org/doi/10.2105/AJPH.80.6.6\

Appendix A: Interview Questions

Interview question thematic alignment

Theme	*Number*	*Question*	*Purpose*
Effectiveness of CBC implementation	2.1	Would you say there is an adequate/appropriate ratio of MH professionals to those in need of their services in your area?	Gains professional insight into the ability of their field to serve the needs of their respective population
	2.2	What community MH resources are available in your area?	Understand what programs have been made available in comparison to other regions from literature review, gain insights into how programs are tailored to individual needs
	2.21	How would you rate participation in these programs?	Evaluate if programs are successful through communal participation
	2.5	Would you say the MH need has been met in your area?	Determine if professionals perceive the local need as having been met
	2.6	Would you say that there are enough programs in your area?	Determine (based on professional opinion) whether or not there is a perceived adequacy in the amount of MH care programs in the area
	3.2	Have you noticed an increase in homelessness after the closure of the institution?	Evaluate based on one indicator of patient success, the extent to which existing programs have helped individuals cope with life outside Hospital N
Efforts currently being made to benefit area	2.4	What efforts has your area made to make these programs well known and destigmatized?	Assesses what community success in destigmatizing programs and making them more available, accessible, and integrated into community life.
	3.3	What is being done to make these programs more well known/accessible to those in need?	Assesses current effort in making programs accessible to individuals in need, determines different methods being used to do so
Current program accessibility	2.3	How many of these programs would you say are covered by Medicare/Medicaid?	Will serve as an indicator of the cost accessibility of community based MH programs
	2.4	What efforts has your area made to make these programs well known and destigmatized?	Identifies strategies for reducing stigma, a major barrier to patients seeking and receiving CBC (Shahwan et. al, 2020)
	3.1	What barriers, if any, do you think prevent those in your community from getting access to CBC?	Identifies barriers in providing CBC with a goal of potentially identify/recommending solutions
	3.3.1	What would you say the barriers to raising awareness and treating clients are?	Identifies what, if anything, is preventing social workers from delivering complete, uncompromising, and quality care to at-risk individuals in need

Appendix B: Coding Tables

Emotional responses of Connecticut MH experts to hospital closure			
Code	*Emotion*	*Definition*	*Supporting statements*
1e.	Stress	Feeling of stress, being overwhelmed with the increased demand for their services which was accompanied by a decrease in financial resources.	"I feel very overwhelmed by the amount because I give therapy, and I do outpatient services and caseload is upwards of 30 people which is a lot" "...I think we were overwhelmed and just trying to keep up with the need and probably not succeeding." "So yeah that [increased mental health crisis calls] puts a huge burden on the resources of the community."
2e.	Resignation	Resignation, helplessness when faced with a demand they believe will never be met	"Demand has never stopped - it never will" "I don't think it [the mental health need] ever will be [met]. We're doing a good job with what we have." "You know, it seems like no matter how big the program's get, There's always more people who need more things."
3e.	Pain	Personal pain related to the closure of the hospital and its negative impacts on their community	"It's like a dying town. They tried many times to revitalize since I've been working there but it still seems like it's a dying town." ...there's pain on the personal and the town level." "I've always wondered - we had some social worker that was trying to intervene and it was a few years back with a mentally ill person outdoors during the day and the social worker was actually killed in the process of trying to do an intervention. I've always wondered if that was one of our folks from the hospital"
4e.	Anger, resentment	Frustration with the current state of affairs, resentment towards the state for perceived apathetic behavior to calls for help	"Society makes choices to criminalize mentally ill people" "Problem that's happened is that the state promised to invest the savings from the closures into the community. They never did that adequately" "...Mental health is forgotten if you don't talk about it. It's not a problem until something like Sandy Hook happens and then you get a national spotlight… Most people don't want to know about mental health until something nasty happens and then then they're asking what happened."

Perceived Successes of Deinstitutionalization according to Connecticut MH experts

Code	*Success*	*Definition*	*Supporting statements*
1s.	Creation of utilized programs	Creation of programs which are widely utilized within the community. This can be indicated through organizational data, MH expert opinions, and the presence of waiting lists	"I think general participation is pretty high. People want to work with case management. They're going to work with case management because case management is going to get them things that they need…" "...The demand has gone up significantly…" "I would like to think that there has been an expansion of services from [redacted] and over the past few years It seems like more and more mental health providers are coming into [redacted]…" "We are never without a waitlist. We always have a waitlist and it's like months deep."
2s.	Accessibility	Creation of programs which are available, affordable, destigmatized, and easy to get access to	"I think everything that I've listed is covered. So all the programs that I said, I think they are needs based and so they get Medicaid/Medicare dollars… they're pretty affordable." "The fact that we've been able to for outpatient services to do Telehealth for the past 11 months has been huge… we've been able to access that part of the population that otherwise would not be getting services. That will probably go away at some point because it's not normally covered by Medicaid and Medicare." "Our target Population as defined by our grants is that the person has to be eligible for medicaid and medicare… you have to have insurance. So people will have Medicaid and Medicare for and or Medicare and some kind of disability income. But we don't actually bill insurance for those services because those are paid for through our SEMA grants."
3s.	Closure of an inhumane institution	Belief that Hospital N was inhumane in its treatment practices and its closure allowed patients to seek more beneficial options (ie, peer support groups, CBC, clubhouses, etc)	" [The current MH system]... is a very carceral system, very power driven. It's ripe for very bad things to happen to people."

Perceived Failures of Deinstitutionalization according to Connecticut MH experts

Code	*Failure*	*Definition*	*Supporting Statements*
1f.	Lack of resources	Lack of funding promised following the 1996 closure of Hospital N	“There's just not enough money. They don't put nearly enough finances into things. We need affordable housing maintaining the programs but it really just seems like mental health is forgotten…” “They raised the rent to where the soup kitchen was… And so they couldn't afford it any more…” “[The] problem that’s happened is that the state promised to invest the savings from the closures into the community. They never did that adequately” “[We’re] ...always told that there’s no money”
2f.	Demographic Challenges	The difficulties associated with working with the MI population can make it difficult to pursue treatment options with them	“We work for people who… might not… want to come out, you know, it's hard to stay in a waiting room if you have anxiety or if you're having you know… psychosis, it can be really difficult to get to a place and get services.”
3f.	State politics	Flaws in state policy have damaged the ability of MH workers to improve the quality of CBC	“If you want to get out you have to do every little thing that they are asking you to do.” “Connecticut loves a task force...They all say the same thing going back to the 1960s” “[We] need to revalue people that we’ve devalued.”