PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS CULTURAL INSENSITIVITY: CONSEQUENCES AND RECOMMENDATIONS FOR THE FUTURE

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Despite the plethora of models and strategies for addressing issues that surround the chronically mentally ill, there remains a paucity of literature that addresses the specific implications of deinstitutionalization on racial minorities. Racial minorities comprise a significant number of the homeless, jailed, and geriatric mentally ill. History and current reality suggest the reasons why some chronically mentally ill blacks and their families have feared the impact of deinstitutionalization. This article examines the Ohio State Department of Mental Health's response to these issues as a possible prototype for statewide coordination for deinstitutionalization. (*J Natl Med Assoc.* 1992;84:1036-1040.)

Key words • psychiatric deinstitutionalization • mentally ill • minorities

In 1955, there were 559 000 patients in state hospitals in the United States; today, at any given time, there are approximately 132 000.[1] Much of the decrease is attributable to deaths, hospital releases, new psychotropic medications, and more restrictive commitment policies. However, a significant number of the chronically mentally ill are now homeless, housed in geriatric nursing homes, or populating overcrowded city and county jails.

These negative outcomes of deinstitutionalization are vital concerns of public policy. A plethora of models and strategies for addressing these issues that surround the chronically mentally ill have been proposed. Despite this plethora, there remains a paucity of literature that addresses the specific implications of deinstitutionalization on racial minorities, who comprise a great number of those homeless, jailed, and geriatric mentally ill. This suggests that deinstitutionalization and its aftermath has been culturally insensitive to the clientele it was meant to serve.

The Minority Concerns Committee of the State of Ohio defined cultural sensitivity as "an awareness, understanding, and responsiveness to beliefs, values, customs, and institutions (family, religion, etc) of a group of people, particularly those of a race or ethnic group different from one's own."[2] Being culturally sensitive, therefore, was defined as not only being aware and understanding, but also as responding to incorporate this awareness and understanding into the process of program planning and implementation. This means that cultural, political, and socioeconomic factors specific to any given community must be taken into account in program development, as they create unique circumstances for the practice of public psychiatry.[3] This article demonstrates the importance of cultural sensitivity in psychiatric deinstitutionalization and the need for greater societal emphasis on such sensitivity.

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FEARS OF DEINSTITUTIONALIZATION

Although the problems with deinstitutionalization outlined above demand urgent attention, past "quick fixes" remind us that caution and prudence are necessary in creating effective solutions to these problems. With hindsight, it is now realized that the era of deinstitutionalization was ushered in with many simplistic notions about what would become of the chronically mentally ill.[4]

Historically, blacks have had no alternative but to rely heavily on public psychiatric institutions for mental health care. Community support systems were not accessible to the majority of black mentally ill, and the likelihood of creating them has diminished as black communities continue to be faced with economic crisis.[5] For the chronically mentally ill minority patient, the public psychiatric institutions were often asylums that provided refuge and protection. The basic necessities such as housing, food, socialization, and medical and psychiatric care were afforded them in these institutions at a time when there were no guarantees that these services would be provided where they resided in their communities. For many, a lack of readily available services in the community still exists.

This history and current reality suggests why some chronically mentally ill blacks and their families have feared the impact of deinstitutionalization. They fear homelessness, incarceration by the criminal justice system, and disclosure in the community—all of which are often the results of deinstitutionalization.

IMPACT OF RACE/CULTURE ON CLIENTS' NEEDS

Talbott cited that one of the disasters of deinstitutionalization in the past was the nonexistence of community facilities for the chronically ill and no provision for supplying the patients with all the services available in the state hospital, such as medical and psychiatric care, social services, housing and food, income maintenance or appropriate employment, and vocational/social rehabilitation.[6] Public psychiatric hospitals in most states retain the bulk of the state's mental health funds at the expense of community services. Community mental health centers attempt to adequately provide comprehensive services to the chronically mentally ill despite insufficient manpower and resources. However, these underfunded community mental health centers tend to give priority to the most accessible and politically influential sector of the community, the middle class.[7] Given that the unemployment rate is highest among minority males, minority mentally ill men are at great risk of not having basic necessities.

Housing has posed a significant burden on community mental health centers in the deinstitutionalized setting. While the incidence of homelessness among ethnic and racial minorities who are chronically mentally ill has not been well documented, the 1984 Housing and Urban Development Report and the 1985 US Conference of Mayors Report indicate that there is an overrepresentation of ethnic and racial minorities among the homeless. To be a chronically mentally ill, homeless, minority person poses a dilemma that goes beyond the vicissitudes that are encountered when mainstreaming other chronically mentally ill individuals into the community.

Although board-and-care homes exist in addition to other residential facilities, the placement of mentally ill blacks still remains a problem in this decade. Carter explains that "because of racial bigotry, many communities object to the presence of blacks regardless of income, level of education, or social skills."[5] Therefore, it seems naive for mental health professionals to assume that black patients can be properly housed outside the black community without resistance. Enacting zoning regulations that confine mentally ill patients to dilapidated inner cities is a socially accepted and legally sanctioned method of housing discrimination.[5] Given this, the state psychiatric institutions, which four decades ago were considered "inhumane asylums," are viewed as a saving grace for some chronically mentally ill.

Homeless, mentally ill minorities are at great risk for incarceration by the criminal justice system. They are often jailed for vagrancy, trespassing, shoplifting, and disorderly conduct. The criminal justice system has, by default, replaced the mental health system as the provider of care to many homeless, mentally ill persons.[8] Mentally ill individuals must thus surrender to a system that is not equipped to provide essential mental health services. The limited amount of community psychiatric resources including hospital beds and the limited tolerance for mentally disordered behavior by society have resulted in pressure to institutionalize persons needing 24-hour care wherever there is room, including in jail. Many of these victims are being incarcerated for minor criminal acts that are manifestations of their illness, their lack of treatment, and the lack of structured activity in their lives.[4] In many instances, inappropriate arrest and incarceration are substituted for hospitalization and psychiatric treatment.[9-11]

Fear of self-disclosure in the community has long been a concern of the chronically mentally ill. What was once concealed through institutionalization is often

revealed to the community with families and clients ill-prepared to face this challenge. With minorities attaching significant stigma to mental illness, humiliation experienced by minority mentally ill and their families within their communities represents a need that has not been addressed. It may be that minority families traditionally have waited until their loved ones were harmful to self or others before actively seeking services from the mental health system.

Racial and cultural differences have an impact on the diagnostic practices that may lead to institutionalization of the mentally ill. Misdiagnosis can occur as the result of cultural distance between the clinician and the patient.[12] This misdiagnosis may lead majority psychiatrists to have a "lower threshold" for identifying psychotic symptoms, and thereby create a greater likelihood for institutionalization among black and Puerto Rican patients.[13] A retrospective study reviewing the diagnostic history of 272 black, manic-depressive outpatients found that these patients had been previously diagnosed as schizophrenic at a 71.7% rate in public hospitals and at a rate of 52.2% in private hospitals, again suggesting that patients from a different culture were prone to be diagnosed as psychotic.[14] The long-term implications of misdiagnosed, culturally different patients remains largely unknown, although there is indication that those misdiagnosed as schizophrenic would be at greater risk for the morbidity associated with neuroleptic-induced tardive dyskinesia.[15]

ACCESSIBILITY OF SERVICE

One of the intents of psychiatric deinstitutionalization was to provide psychiatric services to the chronically mentally ill in the least restrictive environment, namely their communities. The bulk of the funds for psychiatric services still remain in state psychiatric institutions, and the resources of community mental health centers often are not available to many clients. Furthermore, services that are available at community mental health centers are not used by clients because they lack transportation, while others are unfamiliar with the role of the community mental health center.

Lack of transportation is an economic hardship faced by many mentally ill individuals, especially in rural communities. Lack of a convenient public transportation system is often the reality. Furthermore, some rural clients have a high suspicion of urban centers and would prefer services to be rendered in their rural communities.

Some individuals avoid community mental health centers because they lack a clear understanding of the services offered. Traditionally, minorities have relied heavily on informal resources for support and leadership. There are usually strong ties with specific families in the community, church groups, and individuals. Much of the information in the community is disseminated through these community support networks. Studies of support structures in the black community have revealed that "formal and informal resources are mutually exclusive alternatives. Rather, there is a positive relationship between the use of formal and informal resources."[16] Such informal and formal networks can only build on the generally favorable attitudes toward community mental health centers already seen in one northeastern black community.[17]

ADDRESSING THE NEED FOR CULTURAL SENSITIVITY—THE OHIO PROJECT

In January 1986, the Ohio State Department of Mental Health organized a statewide Minority Concerns Committee composed of primary and secondary users of public mental health services, community mental health board members, agency professionals, and community leaders. The committee was charged with investigating and reporting on the delivery and impact of public mental health services on Ohio's ethnic minority populations. Three phenomena were identified as warranting exploration:

- the underutilization of services in the community mental health system by minority populations,
- the lack of participation by members of minority populations, especially black Americans, on agency and mental health boards in consumer and family movements, and
- the minority population's disproportionate utilization of state psychiatric hospitals, especially by black Americans.

The Committee reviewed hospital admissions, inpatient diagnoses, outpatient admissions, vocational rehabilitation needs, readmissions, cultural insensitivity, and minority participation in services. Some of the committee's findings were:

- for black persons, the percentage of admissions to state psychiatric hospitals was three times greater than their representation in the total state population,
- inpatient blacks and Hispanics were diagnosed as severely mentally ill at a greater rate than whites,
- blacks were more apt to be hospitalized than treated at community mental health centers in the eight largest urban areas of the state, and despite the fact that blacks discharged from hospitals contacted

community agencies at higher rates than whites, they received fewer hours of service,

- the paramount rehabilitation issue for minorities was assistance in vocational training and finding a job,
- the cultural insensitivity of mental health professionals discourages minorities from using outpatient services in the mental health system, and
- while blacks are represented on urban mental health boards, only one board had a racial minority as an executive director, and on some boards and agencies, blacks and Hispanics were underrepresented.

In April 1988, the Minority Concerns Committee presented its findings and recommendations to the Ohio State Department of Mental Health and the state governor. The Committee's recommendations addressed training and recruitment, treatment, community relations and public education, planning, and services. It is noteworthy that in all of these areas, multiple agencies of the public sector (mental health boards, the State Department of Mental Health, community mental health centers, university training programs, state hospitals, and the public) were urged to adopt changes that might make them more culturally sensitive.[2] The Committee's recommendations are outlined below.

Training and Recruitment

1. Offer and encourage cultural sensitivity to all board and agency staff in community mental health board areas with ⩾6% ethnic minority population to sensitize staff to the service needs of minorities.
2. The case management curriculum package should include culturally sensitive and relevant inservice training for staff in central offices, the community mental health system, and state psychiatric hospitals.
3. Require that clinical training and residency program curricula include culturally sensitive internships and externships as well as relevant training aimed at preparing students for delivery of services to culturally diverse minority groups.
4. The community mental health system and state psychiatric hospitals should recruit and hire more minority and bilingual staff at all levels.
5. Increase efforts to ensure that board membership reflects the minority representation of each board's service.

Training

1. Fund research to develop and pilot performance outcomes for a reliable and valid diagnostic assessment method, to include appropriate diagnostic instruments that are culturally sensitive.
2. Evaluate factors/conditions related to the observed differences reported between white and minority persons diagnosed with schizophrenia reported in the state's mental hospitals.
3. Designate funding for mental health treatment of Native American Indians through community mental health boards to the American Indian Centers.
4. Inform and sensitize hospitals, community mental health boards, and agencies about the disproportionately large number of minority (specifically black) clients who are receiving the most severe diagnoses and have the highest rate of recidivism. Furthermore, stress the need for more reliable and valid diagnostic procedures, more effective and intensive treatment, medication education, and appropriate discharge planning to reduce recidivism.

Community Relations and Public Education

1. Where the minority population is ⩾6%, the Minority Concerns Committee members in cooperation with the local community mental health board should hold public forums in minority communities.
2. The Office of Consumer Services should work actively within the community mental health board areas with ⩾6% minority population in fostering the development of minority consumer and family groups and/or encouraging minority consumer and family members to participate in existing local groups.

Planning

1. Include racial and ethnic identifiers in all Ohio State Department of Mental Health data collection.
2. Ensure funding of more evaluation, needs assessment, and research on minority mental health issues.
3. Encourage contact and support minority participation in designing and conducting research.
4. The mental health board planning process should reflect an understanding of the needs of minority persons as well as a process for implementing culturally specific policies and service plans.

Services

1. The Ohio State Department of Mental Health should act to decrease black persons' admission and readmission rates to inpatient facilities and to increase quality and culturally sensitive outpatient services.

CONCLUSION

Over the past three decades, psychiatric deinstitutionalization has been debated and restructured, result-

ing in so-called model programs that purported to address the comprehensive needs of the chronically mentally ill. Unfortunately, the importance of cultural sensitivity in the process of psychiatric deinstitutionalization was not given adequate attention at a time when a large number of patients in the state psychiatric institutions were minorities. The system of psychiatric institutionalization, which was criticized for being inhumane and demoralizing, was replaced by a system that disregarded the diversity of the population it served and the implications of providing services. It is appalling that more attention has not been given to what is vital to the success of any comprehensive mental health program: the need for *cultural sensitivity.*

Race and culture have implications in services rendered, diagnoses, and utilization of services. Because race and culture have a tremendous impact on psychiatric deinstitutionalization, lack of cultural sensitivity in developing comprehensive psychiatric care dooms this process to failure. We must learn from the mistakes of the past and do it correctly the first time or fall into the abyss of poor quality with a consequent repopulation of state psychiatric institutions.

It may be argued that over the past decade, great strides have been made to address the concerns of mental illness among minorities. However, if the literature represents the amount of attention given the impact of mental illness among minorities, disproportionately inadequate attention has been given the special needs that profoundly affect the comprehensive services administered to such a diverse population.

The State of Ohio has taken an initial step to address these issues. Much of Ohio's program can be applied to other states and locales. Namely, involvement of individuals from the major racial/cultural groups in every stage of planning for deinstitutionalization, including the chronically mentally ill or their families; education and training of professionals at all levels of services to cultural issues; and continued research to assess the effect of such interventions on the course of illness in all cultural groups.

As the turn of the century approaches, we must address psychiatric deinstitutionalization as a comprehensive process. We cannot afford to limit cultural sensitivity to an entity of its own—it must be inextricably woven into every aspect of psychiatric deinstitutionalization.

Literature Cited

1. Redick RW, Witkin MT. State and county mental hospitals, United States, 1970-1980 and 1980-1981. *Mental Health Statistical Note 165.* Rockville, Md: National Institute of Mental Health; 1983.

2. *Report of the Minority Concerns Committee.* Columbus, Ohio: Ohio Department of Mental Health; 1988.

3. Bachrach L, Lamb R. What have we learned from deinstitutionalization? *Psychiatric Annals.* 1988;19:12-21.

4. Lamb RH. Deinstitutionalization and the homeless mentally ill. *Hosp Community Psychiatry.* 1984;35:899-907.

5. Carter JH. Deinstitutionalization of black patients: an apocalypse now. *Hosp Community Psychiatry.* 1986;37:78-79.

6. Talbott JA. Deinstitutionalization: avoiding the disasters of the past. *Hosp Community Psychiatry.* 1979;30:621-624.

7. Rubenstein LS. Access to treatment and rehabilitation for severely mentally ill poor people. *Clearinghouse Review.* 1986;20:382-391.

8. Morrisey J. *National Institutes of Mental Health-Funded Research on the Homeless Mentally Ill: Implications for Policy and Practice.* Albany, NY: Bureau of Evaluation Research, New York State Office of Mental Health; 1986.

9. Abramson MF. The criminalization of mentally disordered behavior. *Hosp Community Psychiatry.* 1972;23:101-105.

10. Grunberg F, Klinger BI, Grumet B. Homicide and the deinstitutionalization of the mentally ill. *Am J Psychiatry.* 1977;134:685-687.

11. Lamb RH, Grant RW. The mentally ill in an urban county jail. *Arch Gen Psychiatry.* 1982;39:17-22.

12. Gross HS, Herbert MR, Gennell KL, Donner L. The effect of race and sex on the variation of diagnosis and disposition in a psychiatric emergency room. *J Nerv Ment Dis.* 1969;148:638-642.

13. Mukherjee S, Shukla S, Woodle J, Rosen A, Orlarte S. Misdiagnosis of schizophrenia in bipolar patients: a multiethnic comparison. *Am J Psychiatry.* 1983;140:1571-1574.

14. Bell CC, Menta H. Misdiagnosis of black patients with manic depressive illness. *J Natl Med Assoc.* 1981;72:141-145.

15. Kane JM, Woerner M, Lieberman J. Tardive dyskinesia: prevalence, incidence, and risk factors. *J Clin Psychopharmacol.* 1988;8:52S-56S.

16. Jackson JS, Neighbors HW, et al. Findings from a national survey on black mental health: implications for practice and training. In: Miranda MR, Kitano HH, eds. *Mental Health Research and Practice. Development of Culturally Sensitive Training Programs.* Washington, DC: US Government Printing Office; 1986. US Dept of Health and Human Services publication (ADM) 86-1466.

17. Gary LE. Attitudes of black adults toward community mental health centers. *Hosp Community Psychiatry.* 1987;38:1100-1105.