



The Impact of Deinstitutionalization on American Mental Health Care

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Article Details

Article Type: Case Report

Received date: 23rd January, 2026

Accepted date: 18th May, 2026

Published date: 20th May, 2026

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Citation: Salvaggio, M., (2026). The Impact of Deinstitutionalization on American Mental Health Care. *J Soci Work Welf Policy*, 4(1): 194. doi: <https://doi.org/10.33790/jswwp1100194>.

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Abstract

Deinstitutionalization has had a significant impact on the social work profession. Supporting persistently mentally ill individuals is complicated by limited access to community mental health resources. This article aims to describe the historical timeline of deinstitutionalization as well as the stated objectives for individuals and communities. In addition, this work will explore whether and how deinstitutionalization has been successful as well as reflecting upon future treatment directions, advocacy and social change efforts.

Key Words: Deinstitutionalization, Mental Health, Assertive Community Treatment (ACT)

Introduction

In the United States, clinical social workers comprise a significant proportion of mental health care providers. Over the course of the 20th century, this phenomenon has been shaped by decades of systemic change impacted by scientific breakthroughs in the approaches to understanding mental illness, the development of psychotropic medications and political legislation. Deinstitutionalization refers to the movement by which the provision of mental health care shifted from inpatient psychiatric facilities to neighborhood-based, local treatment programs. The purpose of this paper is to first describe and contextualize deinstitutionalization, including historical precursors to this movement, as well as the purported goals for individuals and communities. Furthermore, this work aims to address whether and how deinstitutionalization has been successful as well as its subsequent impact on the field of social work. Finally, the conclusion reflects upon new directions in supporting vulnerable, mentally ill individuals as well as reflecting on the importance of advocacy and social change efforts.

Historical Background

Archaic definitions of mental illness predominated public perceptions in the America of the 1600's and 1700's. Individuals

considered emotionally disturbed were grouped together with other marginalized individuals that struggled to function socially and economically. Supervision of this population was primarily the responsibility of blood relatives as well as community workhouses. Mentally ill patients began to be treated in health facilities starting in 1770, and in 1773 Virginia, a psychiatric hospital opened its doors to the community, ultimately leading to the construction of more than three hundred facilities by 1945 [1]. The asylum became the epicenter of care, a space where many clients lived within the confines of a restricted environment with no outside contact beyond other patients and the clinical workers. Asylums were meant to accommodate mentally ill individuals so that they would be concurrently sheltered from and not intrude upon the typical functioning of the general public [2]. Essentially, inpatient psychiatric facilities were intended to be secure, therapeutic spaces where mentally ill individuals could spend productive lives with varying degrees of success. Some independent programs provided both work and sustenance for participants such as self-sustaining agricultural production, laundry services and bakeries [3].

From the early 20th century to the present day, socioeconomic status was and has been an influential factor to the delivery of mental health care in the United States. The significance of Sigmund Freud's work in psychoanalysis influenced broadening definitions of clinical disorders and the populations served. Psychotherapy treatment emerged in community-based programs with limited availability to people who could pay for their care. In contrast, impoverished individuals experiencing persistent mental illness took up residence in inpatient psychiatric facilities where they often endured failed treatment attempts and psychosurgery [4].

Deplorable conditions of early 20th century psychiatric facilities cannot be understated. Firstly, programs were horribly overcrowded. At the peak of institutionalization in 1955, approximately 500,000 individuals were dwelling in state and county hospitals. Facilities

had far exceeded their capacity, and clinical workers were unable to manage the needs of the patient population. The situation further deteriorated when many medical professionals were drafted into military service leaving programs significantly underserved [3]. Furthermore, societal shifts also affected the growing patient census of psychiatric facilities. Industrialization affected family structures in that the large multigenerational network was changing, and with no one remaining to care for aging family members, they became dependent upon state-sanctioned care [5]. In addition to the elderly, individuals with syphilis and alcoholism also often found themselves institutionalized [6], as well as individuals at the end of their lives [5].

In the context of the dire circumstances of public psychiatric facilities, biological psychiatry emerged to expand the understanding of mental illness, specifically with regard to modern psychopharmacology. This medical model encapsulates mental illnesses as brain disorders and diseases affected by biological factors such as an individual's neurological chemistry, brain anatomy and genetic predisposition. With the introduction of psychotropic medications in the 1950's, this conceptual framework gained traction in showing evidence of the connection between the brain's neurochemistry and symptom management [7]. Chlorpromazine, or Thorazine as it was marketed in the United States, was approved for utilization by the United States Food and Drug Administration (FDA) in 1954. Its various applications included management of anxiety, agitation and delirium for patients experiencing psychosis or mood instability, and by 1956 approximately four million American patients had taken this medication. In contrast to the sedatives typically administered to mentally ill hospital patients, chlorpromazine was the first psychotropic medication that psychiatric professionals actually believed treated mental illness as opposed to simply masking symptomatology. Furthermore, the widespread practice of prescribing Chlorpromazine ushered in a landmark period in the history of psychopharmacology as the American pharmaceutical field created compounds that led to the development of antidepressants, antipsychotics and anti-anxiety drugs for providers to treat a myriad of mental health difficulties [8].

Subsequently, hospitals gained a newfound capacity to release individuals as they seemingly improved on psychotropic medications.

Relevant Legislation

In the 1960's, the federal idealism of John F. Kennedy propelled his focus on both improving the nation's collective mental and physical health as well as aspiring to empower mentally ill individuals to lead independent lives with the aid of psychotropic medications and supportive housing programs. Personal motivations strongly influenced Kennedy's policy agenda as he was emotionally invested in mental health care reform following his sister Rosemary's botched lobotomy [9]. The essence of deinstitutionalization was embodied in the 1963 passage of the Community Mental Health Act that endeavored to provide funding to developing neighborhood-based programs to providing services to mentally ill individuals [1].

Mentally ill individuals returning to the community faced numerous challenges, especially with regard to financial sustainability. Beginning in 1956, the Social Security Administration (SSA) recognized mental illness as a disability, and there were many revisions to the eligibility criteria by which payments were allocated. Financial support would then become available to workers over the age of 50 who had experienced significant mental and physical injuries ostensibly unable to work in the present or future. Over the years, Social Security Disability Insurance (SSDI) legislation broadened the demographic characteristics of individuals that could claim disability benefits. This incorporated younger individuals and those with conditions occurring for at least a year. Medicare coverage was subsequently provided for recipients who were on SSDI for at least two years. By 1972, Congress instituted SSI, a program based

on need for children and adults with identified disabilities. In addition to financial benefits, the majority of SSI recipients have received Medicaid coverage. Although current disability policies continue to provide a mechanism for impaired individuals to receive financial assistance and medical coverage, there are significant constraints as the vast majority of recipients live below the federal poverty level and struggle with lifelong poverty. Despite those struggles, SSI and SSDI recipients do not typically leave the programs unless they are deceased or aging out of eligibility. Numerous factors affect individuals' willingness to explore work possibilities, specifically with regard to fears of losing health coverage, the extraordinarily lengthy process of applying for and receiving assistance and an inability to grasp complicated guidelines regulating benefits [10].

Critiques of the Deinstitutionalization Movement

Despite the reduction in the number of clients within psychiatric facilities following 1963, the scale of change Kennedy envisioned did not come to fruition. In actuality, a limited number of programs were constructed, and community-based mental health care has been a scarce resource for the sizable population of mentally ill individuals in need of treatment. As the clinical knowledge base continues to develop, the reality is that mental illness is multifaceted, complicated by the impact of external stressors and environmental factors. Although psychotropic medications such as Thorazine can assist patients with symptom management, conditions such as schizophrenia or bipolar disorder cannot be eradicated in the same way an antibiotic can cure an infection [3]. Furthermore, Thorazine specifically and psychotropic medications in general have the capacity for causing substantial side effects affecting patients' quality of life. Adverse reactions can range from constipation, dizziness, dry mouth and weight gain to fevers, severe allergic reactions, low blood pressure, muscle spasms, sexual dysfunction and liver injury [11].

Autonomy remains elusive for many psychiatric patients. Transinstitutionalization refers to transferring clients from one institutional environment to another [12]. Approximately 76% of the American homeless population [13] as well as the nearly 44% of those individuals in jails and 37% of those incarcerated in prison settings [14] are estimated to have mental health diagnoses. Innovative approaches are crucial to addressing the dearth of accessible mental health care. One such model is assertive community treatment, ACT as it has come to be known. ACT services originated in Wisconsin in the 1970's and has a developing evidence base of effectiveness research. This approach was established to clinically support vulnerable, severely mentally ill adults at greatest risk of poor outcomes such as psychiatric hospitalization, incarceration and homelessness. Principal characteristics of ACT encompass a focus on recovery through community engagement, a team approach, small caseloads, services provided in the environments and contexts in which they are necessary, crisis service availability on a 24 hour, 7 day a week basis, a centralized service delivery model in which the team provides the necessary services as well as service provision occurring as long as is needed [15]. Compelling data indicates that ACT has demonstrated effectiveness with regard to decreased number of inpatient hospital admissions as well as clients' improved standard of living, enhanced medication compliance, treatment engagement and satisfaction with programs [16].

As is often the case with the American mental health system, the need for ACT teams outpace their availability. Cost concerns have limited the expansion of ACT team services [17], and depending upon the criteria of the particular area's program, clients must document a consistent need for intensive services such as frequent hospitalizations and recent interactions with the criminal justice systems [18]. Social workers are uniquely positioned to utilize advocacy for the expansion of ACT teams through identifying key stakeholders such as elected officials, community group leaders and

social service organizations to gain a comprehensive understanding of current policy affecting clinical practice [19]. States that have either recently launched or expanded ACT services include South Carolina, Florida, Oregon, Indiana and New York showing that advocacy can be a highly effective strategy for service expansion.

Conclusion

Appreciating the sheer magnitude of the impact of deinstitutionalization is essential for social work practitioners. With assessment, treatment and care coordination for individuals in need of services at the forefront of social workers' clinical responsibilities, gaps in service accessibility present formidable challenges. Current estimates purport that approximately two-thirds of American individuals with a mental health diagnosis have been unsuccessful in their efforts to connect with a clinician, despite having health insurance. For individuals presenting in crisis at their local emergency rooms, only one-third received follow-up care within a month of being discharged. This is exacerbated by the fact that more than half of the American population lives in areas experiencing shortages of mental health professionals [20], and although Medicaid has become the most prevalent payer of mental health care services, the insurer has significantly restricted how many inpatient clients can be treated by hospitals and other facilities [3].

A recent review purported several recommendations in supporting the fully realized vision of deinstitutionalization. Firstly, a detailed needs assessment is warranted of the severely and chronically mentally ill American patient population. This is necessary in order to formulate and refine current and prospective service provision models in the community. In addition, these efforts are in need of proper funding to support the construction of new facilities, training initiatives and reinforcement of primary health care [21]. Under the Trump administration, chaotic policymaking has created additional challenges to the safeguarding of mental health care. In early 2026, nearly \$2 billion in funding for mental health and addiction programs were proposed to be cut, and proposed cuts were later reversed following bipartisan political pushback [22]. This is a call to action for clinical social workers to ensure the long-term existence of appropriate mental health services for mentally ill individuals.

Conflicts of Interest: The authors declare no conflicts of interest.

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