WHO WILL FEND FOR THE CHRONICALLY MENTALLY ILL IN THE COMMUNITY?

The Reverend Robert F. Drinan

In 1980, the First Lady, Mrs. Carter, testified before the House Committee on Aging, on which I served, about the necessity of increasing federal funding for problems of mental illness. Mrs. Carter stated that she had received a letter from a senior citizen with these words: "It is a terrifying experience getting older in America. You suddenly find yourself an outsider.... Indeed, one reaches the age where one is considered not to exist...."

The 96th Congress subsequently raised from $250 to $750 the amount of federal funding available under Medicare for a patient with mental illness. What will happen to this increase, however, is uncertain, because of the massive federal budget cutbacks and the promise of more to come later.

All of this is very unfortunate, since mental health problems escalate in a time of recession. People are frightened; the poor, the elderly, the vulnerable are much more likely to have emotional and psychological problems when they feel threatened with regard to their basic economic future.

A GROWING NATIONAL AWARENESS

Despite all of these problems, I am optimistic since in my judgment the public consciousness about the problems related to mental illness has increased dramatically over the past several years. I hope that my judgment is correct when I state that the public consciousness about mental health and retardation is at an all time high in the Congress and in the country.

I became acquainted in the early 1960s with the problems related to mental health and mental retardation when I served as the Chairman of a Commission on Mental Retardation appointed by the governor of Massachusetts. Ever since that time I have been acutely aware of the progress and, all too often, the failures of the mental health and mental retardation movements in this country.

In 1961 President John F. Kennedy called for a "bold new approach" in meeting the needs of the mentally disabled and stated as a specific goal: "Services to both the mentally ill and the mentally retarded must be community-based."
President Kennedy predicted that 5% of those who were institutionalized could be placed in residences outside of those institutions within one generation.

The clarion call resulted in enactment of the Mental Retardation Facilities and Community Health Centers Act in 1963. The federal government has followed up on this pioneer legislation by enacting Medicaid, the Developmental Disability Act, the Rehabilitation Act of 1973 and the Supplemental Security Income Program. Each of these laws has advanced deinstitutionalization.

THE NAGGING QUESTION

Fifteen years after President Kennedy's landmark address, over half of those people who had been institutionalized for mental illness or mental retardation have now left the institutions where they were confined. The nagging question that keeps recurring, however, is: Does deinstitutionalization represent an enlightened revolution or an abdication of responsibility?

The key premise of deinstitutionalization is the concept that a person is entitled to treatment or at least to a residence where he or she can live in a familial setting that is, to quote the Development Disabilities Act, the “least restrictive of the person’s personal liberty.”

The concept that a person has a right to the least restrictive environment has to some extent become the constitutional law of this nation. In 1975 the United States Supreme Court in the decision *O'Connor v. Donaldson* (422 U.S. 804) ruled that no nondangerous person may be deprived of his or her liberty if he or she is “capable of surviving safely in freedom by him or herself or with the help of willing and responsible family members and friends.” With these words, the Supreme Court ratified a policy approved by five Presidents and by eight Congresses. There can, therefore, be no retreat from the basic national policy of deinstitutionalization.

The Congress has followed faithfully, if somewhat inadequately, the fundamental federal policy of allowing people to leave institutions when they can, with assistance, manage their own lives outside of an institution. Congress by mid-1975 was funding 503 community centers, all of which were in full operation. An additional 96 centers had received grants from the National Institute of Mental Health (NIMH) for construction and for staff.

Unfortunately, all of these centers can accommodate only 40% of those who need them. A total of 1,500 centers are apparently needed to meet the needs of those who have a right under the law to deinstitutionalization.

Contemplate the numbers and the vast revolution that has come about in the field of mental health. In 1969 there were 427,700 persons institutionalized for some form of mental illness. In 1977 that number had dropped to 160,000—a drop of 62%.

In Massachusetts the drop is even more dramatic. Inpatients in state mental hospitals in 1969 numbered 21,000. In 1974 the number had dropped to 11,688, and in 1977 the number was 3,262. Of that 3,262, 1,200 were over the age of 65.

However, state budgets for mental institutions had gone up from $2.2 billion in 1969 to $4.4 billion in 1978.