DEINSTITUTIONALIZATION: An Appraisal of Reform

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Abstract

The number of inpatients in US public mental hospitals declined from 559,000 in 1955 to approximately 110,000 at present. Reductions resulted from release or transfer of long-term inpatients and from entrance barriers to new admissions. The timing and pace of deinstitutionalization substantially varied by state, but three quarters of the national reduction followed the expansion of welfare programs in the middle 1960s. The establishment of community care alternatives was highly inadequate, leaving many severely and persistently mentally ill people without essential services. Problems of care were exacerbated by the contraction of welfare programs in the 1980s, which resulted in serious neglect and homelessness. Plagued by underfinancing and fragmentation of care, new strategies in developing mental health care systems include capitation, case-management approaches, and the development of strong local mental health authorities.

INTRODUCTION

President John F. Kennedy first described his proposal for a national community mental health program in a special message to Congress on February 5,

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1963. It was subsequently enacted as the Community Mental Health Centers (CMHC) Act of 1963. In his message Kennedy set a quantitative target for this effort: a reduction by 50% or more of the number of patients then under custodial care, within ten or twenty years (Kennedy 1963). In reality, the process of "deinstitutionalization" proceeded even more quickly and more extensively than that. By 1975, the number of patients in state and county mental hospitals had declined by 62% from the time of the President's message (65% from the peak of 559,000 in 1955). Falling further still over the next decade, the institutional census contracted to 110,000 in 1985 (NIMH 1989) despite growth in the US population and irrespective of the increasing number of mental hospital admissions over much of this period.

Rare, indeed, is it in social policymaking for measured accomplishments to outdistance stated goals. Almost as unusual is the degree of fervid enthusiasm—among mental health professionals, advocates, public officials, and members of the general public—that surrounded initiation of the community mental health movement, of which patient relocation was an essential strategy (Rochefort 1984). For many, the proposed redirection in mental health care represented both scientific and humanitarian progress, a major "psychiatric revolution" to sweep away a dark age of institutional confinement (Grob 1987b). Cameron (1978) has described this mind-set as a new ideological consensus which functioned to provide the political energy and commitment necessary to move away from the existing system of hospital-centered care and its entrenched interests.

After some 35 years of programmatic experience, however, reactions to deinstitutionalization today are much less positive. Another ideological consensus may be emerging, one that identifies deinstitutionalization as one of the era's most stunning public policy failures. Critics underscore, especially, the incomplete development and inadequate performance of the supportive services that were meant to accompany patient discharge and patient diversion activities (see, eg, Dear & Wolch 1987, *Newsweek* 1986, Torrey 1988). Some judge it time to return to a state hospital-based mental health system (Gralnick 1985). Emblematic of these currents is a recent letter to the editor of the *New York Times* by Democratic Senator Daniel Moynihan of New York *(New York Times* May 22, 1989). Pointing to the growing numbers of deranged homeless persons and to the undersupply of community-based mental health care in New York City, Moynihan mused that President Kennedy might have set down his pen before signing the CMHC Act had he been able to foresee such outcomes.

The current controversy and large body of accumulated data make the time opportune for appraising the record of deinstitutionalization in the United States. Seeking to provide a comprehensive overview of its causes, nature, and consequences, this chapter addresses several questions pertinent to this

sociological phenomenon. What sociohistorical forces—before, coincident with, and after Kennedy's community mental health legislation—gave rise to and facilitated the practice of deinstitutionalization? How far has de-institutionalization progressed, and at what rates over time and for different geographical areas? What have been the effects of deinstitutionalization on patients and on the general society? We conclude by discussing the challenges of deinstitutionalization as a policy direction of the modern American welfare state.

ROOTS OF REFORM

Deinstitutionalization offers a compelling case study of the complexities of modern social policymaking. Justly recognized as a major innovation in both the philosophy and the practice of mental health services delivery, the pro-gram evolved over decades and came to stand, for a brief while at least, as a high priority agenda item at the highest level of government. Throughout, many influences were operative, including changing ideas and attitudes about the nature of mental illness and its treatment, biomedical advances, social research, professional currents, legal activism, and the emergence of a power-ful political coalition in support of the mental health reform movement. Just as important, however, the deinstitutionalization experience also illustrates the manner in which forces and events belonging to different policy fields can interact to produce far-reaching, if often unplanned, outcomes.

Sources of Deinstitutionalization

An early impetus to deinstitutionalization derived from World War II and the changing ideologies and experiences associated with it. The environmental and egalitarian notions that developed during this period were related to the horrors of Nazism (Grob 1987b), and these fostered a strong conception of environmental determinism. The experience of psychiatrists during the war in dealing with neuropsychiatric problems during combat promoted a preventive ideology and the translation of military psychiatric techniques to civilian practice. Moreover, the rejection of large numbers of men for the armed services for psychiatric reasons, and the increasing fiscal strain on state mental hospitals with growing patient populations, focussed interest on a broader mental health strategy and a preventive ideology (Mechanic 1989).

  Already by the 1950s, some mental institutions were changing administra-tive practices and beginning a modest process of deinstitutionalization (Bock-oven 1972, Scull 1984). A major impetus came through the introduction of the phenothiazines in the middle 1950s that allowed large institutions to modify administrative policies and to reduce coercive restraints. The new drugs helped control patients' most disturbing psychotic symptoms and gave

hospital staff and families confidence in the potential of less coercive care and hopes of greater predictability of patients' behavior. At about the same time, the National Institute of Mental Health was developing a research and action agenda based on a belief in prevention and the social malleability of mental disorder. With NIMH encouragement, research was undertaken in large hospitals documenting the deleterious effects of hospitalization on patients' functioning, motives, and attitudes (Goffman 1961, Belknap 1956), and such results supported the growing community mental health rhetoric. For the most part, however, the ideology was based on premises that were either un-documented or false (Mechanic 1989). But the mental health rhetoric had a life of its own and served as the basis for federal policy (Grob 1987a).

It is generally assumed that deinstitutionalization began with a vengeance during the middle 1950s with the introduction of new drugs. As we document later, the timing varied substantially by state, and deinstitutionalization was limited in the early years. During the period 1955 to 1965, public hospital populations decreased by only 1.75% a year on average (Gronfein 1985a). While hospitals were now more ready to return patients to community set-tings, they often had no place to send them and no basis for their support in the community.

Deinstitutionalization accelerated in the late 1960s and 1970s with the growth of the welfare state and with the reinforcement of an egalitarian, noncoercive ethic. By the late 1960s, lawyers socialized in the civil rights battles of the decade turned their attention to the rights of the mentally ill with an attack on civil commitment (Ennis 1972, Miller 1976), and the develop-ment of a legal theory supporting patient rights and the least restrictive alternative (Brooks 1974). With changing state statutes, it became in-creasingly difficult to commit patients to mental hospitals. The growth of welfare enabled the large-scale reduction of public mental hospital pop-ulations and provided large economic incentives to state governments to do so. Thus, it became easier to leave mental hospitals and more difficult to be committed.

Influence of Federal Policy

For one hundred years, since the growth of public mental hospitals in the early and mid-1800s, mental health policy in the United States was the domain of the states. With a series of national legislative enactments following World War II that helped foster community mental health and deinstitutionalization practices, the federal government became the prime agent of innovation and reform in public mental health care. It was to continue to play this role for some 35 years, until intergovernmental changes of the first Reagan adminis-tration reestablished the states' primacy in the design and control of local mental health services.

In addition to creating the National Institute of Mental Health, the National Mental Health Act of 1946 provided funding for the development of pilot community care programs in the states and for the training of mental health professionals. Congress created the Joint Commission on Mental Illness and Health in 1955. Studies conducted under its auspices documented the far-reaching problems of mental health care in the United States, and the commission's final report articulated the case for wholesale system reform, including a redefined role for state mental hospitals as smaller, more intensive treatment sites.

Rounding out these unprecedented legislative activities in mental health was the Kennedy administration's Community Mental Health Centers Act, which sponsored the creation of a new type of community-based facility providing inpatient, outpatient, emergency, and partial hospitalization services, as well as consultation and education to other community organizations. By 1980, more than 700 CMHCs had been funded under the program, or roughly half of the 1500 centers projected as needed for nationwide coverage (Foly & Sharfstein 1983). Other shortcomings of the program included a general lack of coordination between CMHCs and local state hospitals, and a tendency among many centers to underserve the severely and chronically mentally ill (Dowell & Ciarlo 1989). CMHCs thus constituted more of a parallel to existing state care systems than a complementary network of services, yet the program did expand the alternatives to traditional institutions while promoting the community care ideology.

Beginning in 1966, and extending to the late 1970s, federal social welfare programs rapidly expanded. Medicare and Medicaid, introduced in 1966, stimulated an enormous expansion of nursing home beds and provided an alternative for many elderly mentally ill and demented patients. Medicaid assumed the costs of care for patients moved from state institutions to nursing homes. Since states paid no more than half of Medicaid costs, they had strong incentives to shift patients to nursing homes where the federal government would share the costs. In addition, the expansion of disability insurance made it much easier to return patients to family and board-and-care settings with sufficient income to contribute to their support. During this period there was also expanded public housing that provided housing opportunities directly, or indirectly, by adding to low-income housing stock. Thus, the expansion of the welfare state contributed to a stronger economic and residential base for deinstitutionalization. The depopulation of public mental hospitals accelerated, with patient populations decreasing an average of about 8.6% a year between 1965 and 1975 (Gronfein 1985a).

Contending Theoretical Explanations of Deinstitutionalization

Varying theoretical interpretations of deinstitutionalization arise from alternative conceptions of the role of the state in democratic capitalist society, from

the degree of credibility given to the self-described objectives of key public actors, and from the phase of the policymaking process described.

One major approach analyzes the landmark community mental health legislation of the early 1960s, recognizing this as the occasion when de-institutionalization became official national policy. This perspective empha-sizes the idealistic and intellectual underpinnings of the community mental health movement, focussing on forces operative in the emergence, formula-tion, and approval of this legislative agenda. A spirit of melioration is seen as a driving force in the era's politics across a spectrum of issues from civil rights, to health care, to the Peace Corps. The pivotal concept of community was itself an infectious one, influential not only in mental health care but also in the design of contemporary antipoverty measures. Scholarly works high-light the part played by a coalition of reformist officials, liberal politicians, and mental health activists in moving community mental health legislation through the decision-making process (Foley 1975, Connery et al 1968). More detailed background analysis relates this elite action to a historical context of shifting social understandings of the problem of mental illness and its treat-ment (Rochefort 1984).

A second school of thought looks beyond these auspicious beginnings of deinstitutionalization to some of its worst consequences, including inadequate follow-up services for discharged patients and large-scale transfers to such settings as nursing and boarding homes. In line with a neo-Marxist view of the state, this perspective views deinstitutionalization as a movement concerned less with patient welfare than with easing the growing public fiscal strain of institutional care. Deinstitutionalization thus represents a new style of com-munity-based social control made possible by the advent of modern federal income maintenance and health insurance programs (Scull 1984). Brown (1985) also describes the development of a new medical-industrial complex under which public funds sustain the operation and profits of proprietary facilities.

Some reconciliation between these divergent characterizations is possible by recognizing deinstitutionalization as a disjointed, nonlinear process in which there has been "loose coupling" of policies and results (Gronfein 1985a). Kiesler & Sibulkin (1987) portray this discrepancy in terms of a distinction between de jure and de facto mental health policy, the former being the prescriptions of enacted law, while the latter is "the net outcome of overall practices, whether the outcome is intended or not." Other authors similarly describe deinstitutionalization less in terms of the rational unfolding of an overarching plan than as a hastily conceived, poorly managed undertak-ing whose thrust has altered over time and across the levels of government that became involved (Mechanic 1989, Lerman 1985, Rochefort 1987). Thus, inadvertence as well as design must be weighted in a complete account of the deinstitutionalization movement (Gronfein 1985a).

DEINSTITUTIONALIZATION TRENDS

Deinstitutionalization has been the "single most important issue" of concern for those in the mental health sphere for the past three decades (Rich 1986). An empirical examination of changes in the role played by public hospitals is central to understanding this process. In addition to an overall pattern of systemic transformation, the data reveal important variations in how this movement developed over time and at the state and local levels. Moreover, far from stimulating the phase-out of all types of institutional care, de-institutionalization practices within state and county mental hospitals actually are associated with the rise of a variety of nontraditional institutions that have acquired an increasingly significant role in the custody and care of the mentally ill.

The National Scene

The most dramatic—and most commonly cited—statistic used to describe the course of deinstitutionalization in the United States is the year-end count of resident patients in state and county mental hospitals. From their initial appearance during the 1800s until the midtwentieth century, these facilities underwent tremendous growth. From the start of the 1930s to 1955 alone, inpatient totals swelled from 332,000 to 559,000 (US Bureau of the Census 1975, p. 84, Table B 423-427). This latter date marks the unofficial onset of deinstitutionalization, followed as it was by consistent annual census declines that only now may be abating (see Table 1). Total resident patients at the end of 1986 numbered 109,939, an 81% reduction from 31 years earlier (NIMH 1989).

A second measure of hospital activity, and one that portrays the de-institutionalization phenomenon in less drastic terms, is inpatient episodes.

Table 1   Resident patients, inpatient episodes, and admissions, state and county mental hospitals, 1950 to 1985

Year	Year end resident patients	Inpatient episodes	Admissions
1950	512,501		152,286
1955	558,922	818,832	178,003
1960	535,540		234,791
1965	475,202	804,926	316,664
1970	337,619		384,511
1975	193,436	598,993	376,156
1980	132,164		[b]
1985	109,939	459,374[a]	[b]

Source: NIMH (1989); Morrissey (1989, pp. 318–319, Table 13-2).
[a] Figure cited is based on 1983
[b] After 1975, NIMH stopped reporting admissions and began reporting patient additions.

Cumulated over all facilities in the nation, this statistic takes account of resident census at the year's beginning plus admissions, readmissions, and returns from leave during the reporting year. Total inpatient care episodes for state and county mental hospitals fluctuated in the neighborhood of 800,000 from 1955 to 1965. Thereafter, it fell steadily, reaching a level of 459,000 in 1983, or 44% below the 1955 number of 819,000. Compared to changes in the inpatient census, then, the number of inpatient episodes in public mental hospitals dropped much less precipitously and not until a decade after the resident patients' decline had gotten underway. The reason for the discrepancy in these two trend lines is that admissions to state and county mental hospitals—one of the principal components in the episodes calculation—continued to increase throughout the 1950s, 1960s, and early 1970s, offsetting until 1965 the simultaneous census reductions (Kiesler & Sibulkin 1987, Witkin et al 1987).

At the same time that other operational measures have fallen, the period of time most inpatients spend within state and mental hospitals has also shortened. Average length of stay went from 421 days in 1969 to 143 days in 1982 (Kiesler & Sibulkin 1987). Median length of stay, a better measure of typical hospital stays since its value is less sensitive to the inclusion of a comparatively small number of long-term inpatients, declined as well—from about 41 days in 1970 to 23 days in 1980 (Manderscheid et al 1985).

Despite a general diminution in their service responsibilities, state and county mental hospitals have remained relatively stable in number over recent decades. In 1986, there were 286 such institutions in the United States, 11 more than in 1955. Between the two points in time, the highest count occurred in 1973, at 334 hospitals (NIMH 1989). On the other hand, the size of these public facilities assessed in terms of average number of inpatient beds has dropped sharply, from 1311 in 1970 to 467 in 1984. Considered in conjunction with the nation's population growth during this same period, the change is noteworthy. Beds per 100,000 civilian population went from 207.4 in 1970 to 56.1 in 1984 (Witkin et al 1987).

The Uneven Pace of Deinstitutionalization

Longitudinal analysis shows that deinstitutionalization did not occur at a steady rate (see, e.g., Gronfein 1985a, Lerman 1982, 1985). Inpatient declines during the late 1950s and first half of the 1960s were modest, especially compared to those that followed in the late 1960s and 1970s (see Figure 1). Broken into a series of five-year intervals, the data show an aggregate decrease of only 4.2% for 1955–1960, and 11.3% for 1960–1965. By contrast, the cumulative decreases for 1965–1970, 1970–1975, and 1975–1980 were 29.0%, 42.7%, and 31.7%, respectively (calculated from NIMH 1989). Of the total census reduction of approximately 449,000 that took place
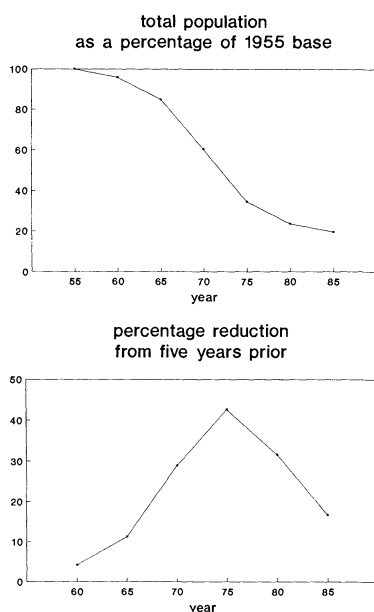
Figure 1   Resident patients in state and county mental hospitals: total population as a percentage of 1955 base and percentage reduction from five years prior

between 1955 and 1985, more than three quarters occurred in the period 1965–1980.

The major impact on deinstitutionalization of the federal health insurance and income maintenance programs that were established or expanded in the late 1960s and early 1970s has already been noted. The above data further underscore the importance of these programs. Community mental health ideologies and even the availability of powerful tranquilizing drugs prior to 1965 failed on their own to drastically alter longstanding patterns of care. Only when these new ideas and treatments were joined by the financing of residential alternatives did the system respond on a large scale (Mechanic 1989).

Noting this unevenness in the historical development of deinstitutionaliza- tion, Morrissey (1982, 1989) describes two fundamentally different phases. The "benign" phase which occurred between 1956 and 1965 consisted chiefly of "opening the back doors" of the state institutions to place new admissions and less impaired long-term residents in alternative settings. Many hospital treatment programs were also revitalized in this period. Following this was a "radical" phase from 1966 to 1975, which saw the "closing of the front doors" of these facilities. At a time when many states were experiencing economic

hard times, hasty downsizing of residential populations and institutional capacity through patient diversions in addition to massive discharges provided a way of avoiding the expensive hospital improvement programs that new court and regulatory requirements often demanded. Community mental health and patient rights activists joined in support of this development.

Change at the Subnational Level

Corresponding to the lack of uniformity in deinstitutionalization over time is the striking variation among states. Table 2 provides information on the rates of public hospital depopulation across the states for two selected periods, 1967–1973 and 1973–1983. In both instances, values are widely dispersed— no single census reduction category contains as many as half of all states, and the difference between the highest- and lowest-ranking states in the later time-frame exceeds 100 points (signifying that even in this, the heyday of deinstitutionalization, some states experienced a countertrend of hospital inpatient increases). Focussing on the 1956–1965 and the 1966–1975 periods, Gronfein (1985b) found the degree of interstate heterogeneity in de- institutionalization to be greater during the earlier period. Rich (1986) sim- ilarly identifies several distinctive configurations for the pace and timing of state hospital inpatient declines in 18 states between 1950 and 1978.

Such variability is consistent with the idiosyncratic nature of individual state mental health systems, which developed for most of their histories free from the standardizing influence of a national mental health policy. A number of factors helped to shape differential state responses to the deinstitutionaliza- tion movement, including the starting condition of each state system in the

Table 2   Percentage reduction in year-end resident patients by state groupings, 1967 to 1973 and 1973 to 1983

	Number of States	
Percentage reduction	1967–1973	1973–1983
0% or negative	0	3
1–20%	5	2
21–40%	22	11
41–60%	19	24
61–80%	5	10
81–100%	0	1
Mean reduction	38.8%	46.3%
Range	62.4	119.5
Standard deviation	15.1	23.2
Coefficient of variation	.39	.50

Source: Calculated from Taube (1975, p. 15, Table 4) and Greene et al (1986, p. 15, Table 3). Includes District of Columbia

late 1950s (e.g. the number of state hospitals and the size and composition of their populations); the relative strength of the political base of public mental institutions within the state; the fiscal structure of state mental health services, especially cost-sharing arrangements between state and community entities; the vigor and efficacy of the indigenous community mental health coalition, including its civil libertarian contingent; and the amount of economic strain faced by a given state with the stagflation of the 1970s (Morrissey 1982). Unfortunately, there are few detailed qualitative studies of individual state care systems in this period, making it difficult to trace the relative impacts of such determining features.

Federal influence was strong but indirect. Empirical analysis confirms a significant positive correlation between state hospital inpatient declines and states' involvement in the Medicaid program, particularly in regard to Medicaid payments to nursing homes (Gronfein 1985a). In contrast, neither the introduction of psychotropic drugs in the late 1950s and early 1960s nor CMHC activity in the 1970s—two of the most commonly cited causes of deinstitutionalization—were found to be statistically related to deinstitutionalization trends (Gronfein 1985a,b, 1986b).

Rise of Nontraditional Institutions

With state and county mental hospitals progressively depopulating, other institutional providers gained importance as locations for the treatment and/or residence of mentally ill persons. Private mental hospitals, admittedly a small component, increased 80% in inpatient episodes over the course of the 1970s (Kiesler & Sibulkin 1987). Most dramatic has been the change in service activity of general hospitals. Many established new special psychiatric units, and others admitted mental patients to beds in medical and surgical units. Between 1965 and 1980 there was a six-fold increase in psychiatric inpatient episodes in general hospitals without psychiatric units (Kiesler & Sibulkin 1987). The general hospital has become the leading provider of acute inpatient psychiatric care.

Many elderly mentally ill were transferred from state hospitals in the 1960s and 1970s. Nursing homes continue to receive many chronically mentally ill aged (together with a very much smaller inflow of nonelderly mentally ill) directly from the community and from short-term hospitals. Of the approximately 1.5 million patients currently in nursing homes in the United States, the proportion having a serious psychiatric disorder or dementias may be somewhere between 30 and 75%, depending on how mental disorder is defined (Linn & Stein 1989). And in the community setting, a host of nontraditional institutions have appeared in the form of board-and-care homes, halfway houses, supervised apartments, and other residential facilities. Together these now provide living arrangements for perhaps as many as 300,000–400,000 chronically mentally ill persons (Segal & Kotler 1989).

Deinstitutionalization and Other Problem Populations

Over the past few decades deinstitutionalization has emerged as a principal theme of policy and practice in several other human service areas as well, including developmental disability, physical disability, and corrections (De-Jong 1979, Lerman 1982, 1985, Scull, 1984). Dimensions of this movement are reflected in such measures as a decline in the rate of institutionalization in state mental retardation facilities (from 97.7 per 100,000 in 1965 to 46.8 per 100,000 in 1985) (US Bureau of the Census 1987), reduced use of public training schools for delinquents (whose rate of institutionalization dropped from 98 to 69 per 100,000 youths over 1970–1977) (Lerman 1985), and the increasing percentage of releases on parole from state prisons in the 1960s and 1970s (attaining a level as high as 70%) (Sykes 1978). More recently, supervised home release has increasingly been used for prisoners.

Several key parallels can be drawn between developments within these other deinstitutionalizing areas and mental health (DeJong 1979, Sykes 1978, Lerman 1982, 1985, Rothman 1980, Scheerenberger 1983, Scull 1984, Tyor & Bell 1984). As a frequent scenario, the deinstitutionalization impulse emanated from a combination of sources—ideological, judicial and economic. In part, there was intellectual cross fertilization from mental health to these other fields, but each field also gave birth to its own concepts. Typically, court orders insisted on improved institutional conditions, and availability of increased federal funding for new services also shaped alternatives. Growth of nontraditional institutional forms (halfway houses, foster homes, group homes, treatment centers, etc) developed in all sectors. And in every case, deinstitutionalization eventually stimulated public debate over the method and impacts of program implementation. But important differences exist between these other human service systems and mental health. No other area experienced the scope of deinstitutionalization characteristic of the mental health sector. Institutional-noninstitutional patterns within these respective systems also vary. Whereas new service modalities in mental health developed mostly parallel to traditional institutions and as an alternative, in mental retardation many new residential care facilities are physically a part of the state institution (Lerman 1985). Similarly, expanded community programs in criminal justice, unlike mental health, operate in tandem with a sharply increasing institutional population and a movement to construct additional prison facilities (Scull 1984, *New York Times* May 17, 1987).

Deinstitutionalization in Perspective

Deinstitutionalization arose from complex interacting social forces, was implemented with startling rapidity, and is now beset by political and professional controversy. Such circumstances are conducive to misperception and misunderstanding. Clearly, state and county mental hospitals no longer

occupy the preeminent position they once did within the US mental health system. By the same token, however, one should not neglect the significant place that these institutions maintain in contemporary mental health services. By a wide margin, state hospitals remain the foremost provider of total inpatient days of psychiatric care (Kiesler & Sibulkin 1987), and they care for many of the most difficult, troubled, and violent patients. These institutions also continue to house a sizable number of long-term patients—according to one estimate, nearly 20% of their patient population at any point in time have been hospitalized for 20 years or more (Morrissey 1989). State hospitals are reported to absorb nearly two thirds of the expenditures of state mental health agencies (Lutterman et al 1987), although these figures may be exaggerated by the way such data are collected—hospital outreach and community care programs are reported as part of hospital expenditures, and not as a contribution of community care.

Extraordinary growth in the mental health sector as a whole coincided with the deinstitutionalization movement, and it is perhaps this conjunction of historical occurrences that induces premature reports of the death of the public mental hospital. Patient care episodes in specialty mental health organizations, for example, rose from 1.7 million in 1955 to 6.9 million in 1983. An important change from inpatient to outpatient care underlay this increase: In 1955, the distribution of episodes favored inpatient care by a 3.42:1 ratio; in 1983, the ratio was 2.69:1 in favor of outpatient care (Morrissey 1989, pp. 318–319, Table 13–2; see also Thompson et al 1982). Klerman (1982) estimated a sixfold increase in the population's use of mental health services over this period. With more persons being treated for mental illness, the probability of a typical patient having contact with state and county mental hospitals has been much lowered (Morrissey 1989). Most patients now being treated by community agencies and alternative institutional facilities would not have been in public mental health systems in prior decades. This overall growth of the mental health sector has played a major part in the transformation of the role of state and county mental hospitals (Kiesler & Sibulkin 1987). It has increasingly become the system of last resort for the uninsured, the treatment resistant, and those who are most difficult to relocate to other settings.

The growth of health insurance covering mental health benefits, concurrent with deinstitutionalization, helped transform mental health care. The most significant single change was the development of the general community hospital as the major site for acute psychiatric inpatient care. Many general hospitals developed specialized psychiatric units, and by 1987, the general hospital accounted for some 1.8 million admissions a year of patients with primary diagnoses of psychiatric illness (National Center for Health Statistics 1988). Medicaid became a major source of payment for inpatient psychiatric

care in general hospitals for many chronic patients, contributing to a pattern of episodic hospital care characterized by short lengths of stay with little community follow-up (Mechanic 1989).

As care for the most severely mentally ill patients shifted from public institutions to community care settings, the functions traditionally associated with public mental hospitals remained but were now more dispersed among varying community agencies and different levels of government. Severely disabled patients still required medical and psychiatric care, housing, psychosocial and educational services, a program of activities, assistance in attaining welfare benefits, and supervision of their medication and daily routines. The strategic task of integrating these functions outside of institutions is a formidable one, and there is persistent evidence of failure in meeting these needs in even the most rudimentary ways (Torrey 1988; Mechanic 1989).

A Note on Cross-National Experience

Even in the United States deinstitutionalization proceeded differently among the states, depending on the structure of their mental health systems, social and economic conditions, the power base of interested constituencies, and the strength of the mental health reform movement. Comparative analysis is extremely difficult with nations that vary greatly in their economic and political systems, and in the structure of their health care and welfare services. Some analysts examine deinstitutionalization in the context of the rise of the welfare state and the way "in which group interests were aggregated, represented and mediated," and its specific urban manifestations (Dear & Wolch 1987). However, few studies garner data from localities in more than one or two countries.

Information and new technical approaches diffuse rapidly throughout the world and, thus, ideas about deinstitutionalization and the value of neuroleptic drugs were widely available in the developed countries by the late 1950s. Moreover, experience in community living for the mentally impaired has long existed as in Gheel (Belgium) and other communities. In contrast, ideologies, leadership, political participation, social control, and the organization of health and welfare are not specific only to nation, but also to locality. In England, a source of many of the social psychiatric ideas about community care, the population of mental hospitals began to fall around 1954 with the introduction of reserpine and chlorpromazine, ideas about therapeutic communities, and change in administrative practices (Brown et al 1966, Wing & Brown 1970). Despite much experimentation with alternatives and rehabilitation approaches, deinstitutionalization in Britain never developed the momentum seen in the United States. Many reasons may account for the contrast including the fact that British psychiatry is a hospital-based consulting specialty; the focus of interest in Britain is on therapeutic hospital alternatives; a

cultural environment supports incremental change; and a different social history affects the management of the impaired elderly.

Canada followed a course similar to that of the United States, although deinstitutionalization occurred later and to a smaller extent. In Ontario, for example, patients in provincial asylums increased until 1960 to a peak of almost 19,507 but by 1976 was 5,030 (Dear & Wolch 1987). De-institutionalization in Australia has accelerated in recent years, influenced by American programs (Hoult 1987).

Despite these commonalities, deinstitutionalization has not been universal. In much of Europe, where a medically oriented, hospital-based psychiatry is dominant, the treatment of serious mental illness remains substantially centered in hospitals. In Austria, for example, there is extremely strong resistance to community-based care and little deinstitutionalization. In Japan, private psychiatric hospitals are growing rapidly and are replacing informal sources of care (Ikegami 1980). Deinstitutionalization must be seen in relation to a nation's values and in the historical context of its political, economic, social, and health and welfare institutions.

In recent years much attention has focussed on deinstitutionalization in Italy, and particularly in Trieste, which closed its mental hospital. This movement, based on the ideology of Franco Basaglia, a Venetian psychiatrist, viewed hospitalization as psychiatric repression and deinstitutionalization as one element of a class struggle. As in the United States in the 1960s, hospitalization is viewed as a cause of illness and disability. The dilemmas of mental illness are explained in the light of struggles among interests over power and control of social institutions (Lowell 1985). Good data are difficult to obtain, and there is much controversy and conflicting views about the changes that have spread throughout Italy. There is indication of significant transfer of patients to other institutions, no longer called hospitals. As in the United States, the evaluation of the consequences of change depend very much on appraisals of local situations in a context of large variability.

IMPACT OF DEINSTITUTIONALIZATION AND FUTURE NEEDS

The long-term care patients who had been resident in mental hospitals prior to deinstitutionalization, if still surviving, are now relatively elderly and are not a major focus of the controversy that rages around the issue of de-institutionalization. Indeed, long-term studies of the course of schizophrenia in the United States and abroad demonstrate persuasively that with time the most severe symptoms abate and schizophrenic patients can make reasonable adjustments to the community (Harding et al 1987a, b, Bleuler 1978, Ciompi 1980). Older patients in the United States released from mental hospitals were

relocated in nursing homes, sheltered care facilities, and families. Some were demented patients who had been kept in mental hospitals because of a lack of alternative institutional settings. Others were elderly patients whose psychotic symptoms had substantially abated but who retained social disabilities due to their long confinements.

The deinstitutionalization debate confuses this population at more advanced ages who were relocated from public hospitals to other settings during the decades of rapid deinstitutionalization with new cohorts of seriously mentally ill patients who are now part of an entirely different system of care (Mechanic 1987). It is this younger population of patients with psychoses and personality disorders, socialized in different cultural and treatment contexts, who are often difficult to manage and who frighten the community. These younger patients often resist the idea that they are mentally ill, are uncooperative with treatment, abuse alcohol and drugs, and generally live an unconventional style of life (Schwartz & Goldfinger 1981, Sheets et al 1982, Pepper & Ryglewicz 1982). Much of the debate, however it is framed, really focusses on this new and growing population of severely mentally ill youth and young adults. The problem is exacerbated by demographic trends that result in large subgroups in the population at ages of high risk for occurrence of schizophrenia and substance abuse (Mechanic 1987).

In the United States, the problems have also become more visible and acute with the contraction of public programs during the 1980s. Recall that the large waves of deinstitutionalization occurred with the expansion of social welfare activities in the late 1960s and 1970s, particularly Medicaid, SSI and SSDI, housing programs, and food stamps. These programs provided the subsistence base essential for relocating patients to the community. This subsistence base was not maintained relative to the growing numbers of seriously mentally ill persons, and in many instances it substantially shrank. Federal and state governments faced with budget deficits tightened eligibility, benefits, and reimbursement in the Medicaid program so that by the 1980s, only two fifths of the poor were covered (Curtis 1986). The Social Security Administration (SSA) faced with growing disability rolls was directed by Congress to review the eligibility of disability recipients. Vast numbers of the disabled mentally ill lost their benefits, although many were subsequently reinstated by the courts (Osterweis et al 1987). Government subsidy of housing also underwent a contraction in the 1980s, making low income housing in many cities extraordinarily difficult to obtain and contributing to the growing numbers of the homeless. In short, the enabling factors that made significant de-institutionalization possible greatly eroded in the aftermath.

The cutbacks in social programs particularly affected the seriously mentally ill. Although some evidence suggested that on occasion the SSA specifically targeted the mentally ill for disability review, the vulnerability of this popula-

tion was probably due more to their relative youth. As a general economic strategy, the SSA was more motivated to excise from the disability rolls younger persons who were likely to draw benefits for many years than those at older ages. As in the case of other welfare entitlements, aggressive advocacy on behalf of the mentally ill over a period of years resulted in reinstatements to the disability rolls of significant numbers of persons. In respect to other benefits such as housing, the mentally ill have been particularly vulnerable because they typically lack bureaucratic skills to gain eligibility, and administrators who run these generic programs have little appreciation of their special needs. In addition, the mentally ill suffer considerable stigma and discrimination relative to other eligible competing groups such as the poor elderly. In recent years, mental health programs have become more aggressive in helping the mentally ill attain eligibility for Medicaid, SSI, and housing benefits, but in an environment of shrinking resources.

Homelessness and Deinstitutionalization

Estimates of the numbers of the homeless range widely (US Department of Housing and Urban Development 1984, US General Accounting Office 1985, Institute of Medicine 1988), and it is difficult to know precisely the size of this changing population. Analysts also differ in their definitions of homelessness, making comparability among estimates difficult. Estimates of the homeless range from two hundred thousand to more than two million (Institute of Medicine 1988). There is broad agreement, however, that the homeless population has been growing. A significant proportion of the homeless suffer from mental impairments. There are no extensive studies using rigorous standardized psychiatric tools, but most of the smaller studies suggest that between a quarter and a half of the homeless have significant psychiatric symptoms (Bassuk 1984a, b, Lamb 1984, Rossi et al 1987). For example, one in four of the Chicago homeless reported having been in a mental hospital for stays of over 48 hours. Nearly half exhibited levels of depression that suggested a need for clinical attention (Rossi et al 1987). The proportion of homeless that acknowledge a history of psychiatric hospitalization ranges from 11 to 33%, across studies (Institute of Medicine 1988, p. 52).

Opponents of deinstitutionalization have used estimates of the homeless mentally ill to discredit current mental health practices, arguing that deinstitutionalization causes homelessness (Appelbaum 1987, Wyatt & DeRenzo 1986). Others associate homelessness mainly with poverty, the diminishing supply of low-cost housing in many areas, and the inability of low-income persons to afford available housing (Rossi & Wright 1987). No one contests that many of the homeless have profound medical and psychiatric needs, but the impact of deinstitutionalization is quite another issue. While homelessness stems from the unavailability of housing and is exacerbated by

the symptoms, vulnerability, and stigma of the mentally ill, its link specifically to deinstitutionalization is less clear. Studies demonstrating that substantial numbers of the homeless have psychiatric symptoms, or have a history of psychiatric treatment, are not sufficiently precise to identify persons who would have had illnesses or disabilities sufficient to require long-term hospitalization under policies prevailing prior to deinstitutionalization. Putting some of the mentally ill homeless into institutions would obviously reduce the homeless population but would not address the basic causes of homelessness. Thus, the entire debate generates far more heat than light. There is little evidence to support the contention that deinstitutionalization is the primary cause of homelessness; it is one of many interacting causes (Rossi & Wright 1987, Mechanic 1987).

In contrast, homelessness and inappropriate housing options pose extraordinary problems for the effective administration of mental health services. Housing problems are a major impediment to effective care and contribute to episodic hospitalization. Many public mental health authorities view housing deficiencies as their most serious programmatic shortcoming and report that only a fraction of the needed housing appropriate for their patients is available (Aiken et al 1986). The lack of suitable housing remains a major barrier in many mental health systems to releasing from mental hospitals patients who are judged to be legally and clinically ready for discharge. Mentally ill persons require a range of housing options depending on their assets and vulnerabilities ranging from highly supervised residential units to independent living. But a reasonable range of options is unavailable in most communities (Randolph et al 1989). A major demonstration effort is now underway in nine large cities to develop mental health authorities that have the capacity to develop and manage housing options for the seriously mentally ill (Aiken et al 1986).

ALTERNATIVES TO MENTAL HOSPITALIZATION

A large number of studies have documented that alternatives to hospitalization, whatever the specific programmatic features, attain better results by a number of outcome criteria as compared to traditional hospital care. Kiesler and Sibulkin (1987), for example, identified 14 experimental studies, most with random assignment, comparing hospital treatment to some alternative care arrangement. They conclude that alternative care is more effective than hospitalization across a wide range of patient populations and treatment strategies.

Documenting that a particular pattern of care is effective is only one aspect of developing a viable system of care. The larger challenge is developing financial and organizational arrangements assuring that such care could be

made available to a widely dispersed population. The basic task is a difficult one, and the existing fragmentation of responsibility and financing poses large barriers to coordinating the needed services. Three initiatives intended to deal with these issues include case-management, financing arrangements based on capitation, and the development of public mental health authorities.

Case Management

Case-management is the device most commonly advocated to deal with the inefficient coordination of services needed by the chronic mentally ill. Case-management usually refers to a process of integrating the elements of a client's total care, filling in gaps by either providing services directly or arranging for necessary services, and insuring that the client receives essential entitlements. There is, however, little consistency in the conceptions of case-management or in its implementation. Even within the more limited legislative context of Medicaid programs and demonstrations, definitions of case-management are characterized by a lack of clarity and consistency (Spitz 1987). Case-management roles vary from therapeutic care to tasks solely concerned with garnering entitlements and coordination. Those who perform these roles vary enormously in training, position, salary and career structures, authority, and control over resources. They often find themselves in conflict between treatment goals and cost-containment pressures from the agencies that employ them (Dill 1987). The gaps between the rhetoric and realities of case-management are large.

In one of the few systematic studies examining a particular case-management strategy, 417 chronically mentally ill were randomized into experimental and control groups. The control group had access to all services other than case-management, while experimental patients were assigned to a unit staffed by eight experienced case-managers and a supervisor (Franklin et al 1987). During the study, case-managers spent about half their time providing nonclinical services to patients and two-fifths of their time brokering services. The follow-up at 12 months found that the patients in the experimental group received more services, were admitted to inpatient care more frequently, and were more costly to manage. There were some tendencies in favor of the experimental group on quality of life measures, but they were small and not statistically significant (Franklin et at 1987). This study suggests the importance of clarity in defining case-management models and the necessity for their careful evaluation.

Case management is a function that can be examined on its own terms or viewed as an approach embedded within a larger service strategy. How case management fits within the goals and operational approaches of an agency may affect its performance on critical indicators. In Wisconsin's Training in Community Living (TCL) Program, case management teams are used for

aggressive community-based care organized within a well-articulated system of services (Stein & Diamond 1985). The effectiveness of the TCL program has been demonstrated and has now been widely replicated (Stein & Test 1985). Case-management teams are so significant a component of this program as to be inseparable from the larger system of care. Case management is a function and not a total service. Its evaluation must be understood within the context of a particular system of care.

Capitation as a Financing Strategy

Capitation is a predetermined payment for a specified set of services for individuals over a defined time period. It has been used extensively to pay general practitioners in Europe and in HMOs in the United States. The basic idea is that the provider receives the identical prepaid reimbursement per person regardless of levels of utilization. Capitation disconnects the link between services and fees for service, and modifies the incentives affecting provider behavior. One theory is that capitation allows the clinician to provide services on the basis of need independent of fee considerations. The evidence indicates, however, that capitation mechanisms in contrast to fee-for-service approaches result in a lower intensity of services. Capitation in mental health has been applied in two ways: mainstreaming the mentally ill into HMOs and by developing mental health HMOs (Mechanic & Aiken 1989).

In the case of mainstreaming, mental patients supported by public programs such as Medicaid are enrolled in existing HMOs that take responsibility for providing an expanded range of mental health services for these enrollees. The single largest demonstration of mainstreaming the mentally ill in Minnesota was terminated because of operational problems (Christianson et al 1989), and we have relatively little direct data on treatment outcomes using this approach. Research, in general, on the performance of HMOs with chronic patients suggests the need for caution in mainstreaming (Schlesinger 1986). In addition, HMOs provide a much lower intensity of mental health care than is evident in fee-for-service practice (Wells et at 1986). The data necessary to link intensity of care with outcomes remain undeveloped.

The idea of capitation in general medical care is one based on sharing risk across a population. It is assumed that some will need care and others not, with one group balancing the other. In contrast, most of the chronically mentally ill require fairly intensive services, making the risk-sharing concept less pertinent. Those developing mental health HMOs, however, seek to use capitation as a strategy to consolidate financing, focus responsibility, and reduce services fragmentation. By capitating chronic mental patients, they anticipate greater flexibility in managing care than is now possible with categorical funding streams, and they hope to aggregate sufficient resources

to develop new needed services. Also, by linking capitation to care for specific chronic patients, they hope to ensure that these typically neglected patients receive appropriate attention.

The effectiveness of using capitation as a strategy to consolidate resources and to focus attention on the care of a neglected group remains unclear. Major efforts have been undertaken in a variety of localities including Rochester, New York (Babigian & Marshall 1989) and Rhode Island (Mauch 1989), and others are in the process of development. Existing experience suggests that developing a viable capitation approach requires much planning and very careful implementation, and there are many unanticipated difficulties (Mechanic & Aiken 1989). Yet, it constitutes one of the more exciting potentials to develop managed care for the chronic mentally ill within our unwieldy health care system.

Mental Health Authorities

The mental health authority, like capitation, represents an effort to focus authority, capacity, and responsibility in caring for the chronic mental patient in the community. Various groups seek a new public or nonprofit entity to take charge, given the fragmentation of responsibility and lack of coordination among community mental health and welfare agencies. Such an organization is seen as having the authority and resources to direct care for public patients by developing its own services or by contracting with other community entities. Authorities would receive federal, state, and local funds for mental health services and have more discretion in their use than is characteristic of many existing categorical programs. Some regions have developed mental health boards or other broad agencies with the authority to receive mental health funds from diverse sources and to make allocations for care with more discretion than many categorical programs allow. With the support of the Robert Wood Johnson Foundation and the US Department of Housing and Urban Development, efforts are now underway in nine cities to develop public authorities with greater clout and a capacity for increased flexibility (Aiken et al 1986). The promise of this strategy will be assessed through an extensive evaluation directed by Howard Goldman at the University of Maryland School of Medicine.

CHALLENGES OF DEINSTITUTIONALIZATION AS PUBLIC POLICY

The notion of returning to a state hospital-centered mental health system would be unrealistic today, even if such a course was seen as desirable.

Thirty-five years of deinstitutionalization and the growth of a broad range of services have resulted in a decentralized, pluralistic mental health sector funded by a diversity of public and private programs. Thus, a monolithic hospital-based system is an impractical model from both an organizational and a political standpoint. Especially in this era of government deficits, it would be prohibitively expensive to upgrade and expand hospital facilities to the point where they could provide a decent living environment and continuous appropriate treatment to large numbers of patients. A well-planned, treatment-oriented, hospital-based system is not inconceivable, but without substantial reinvestment, state mental hospitals would quickly degenerate into the human warehouses of the past. Moreover, a policy of long-term institutionalization is inconsistent with the principle of care in the least restrictive setting that now stands as accepted legal doctrine in our society and is the conditioned expectation of persons who receive mental health services. Finally, the idea of a hospital-based system is inconsistent with a large body of research showing that alternatives to hospitalization improve function and quality of life relative to hospital-based care (Kiesler & Sibulkin 1987).

The impulse for reinstitutionalization reflects a longstanding tendency within the mental health field toward vacillation between hospital and community alternatives (Rochefort 1988). These debates typically neglect the complex nature and variety of mental disorders and the full spectrum of service programs required (Grob 1987b). The present challenge of deinstitutionalization as public policy is to avoid this cyclical trend by ensuring that community and hospital sectors come to play complementary roles in an integrated system, providing patients with care suited to their distinctive needs and capabilities. Necessary reforms in mental health financing and service delivery have already been described. We conclude by noting some of the larger social policy issues.

Deinstitutionalization is one of a group of social initiatives of the 1960s that began with great expectations but resulted in a neoconservative backlash against government interventionism. For many of these initiatives, including deinstitutionalization, a distorted public image has taken hold that exaggerates the dimensions of failure while ignoring positive accomplishments (Schwarz 1988). Even in a more balanced assessment, however, the reality of disappointing performance is plain and underscores the difficulty of translating reformist policy design into effective programmatic action. This has come to be known in the policy sciences literature as the implementation problem (Bardach 1977, Williams 1980).

Implementation difficulties have undermined the deinstitutionalization effort from its inception and are evident in such basic disjunctions as the neglected relationship between community mental health centers and state

hospitals. Coordination processes of this nature, like those essential to the creation of a comprehensive sociomedical support system for chronically mentally ill persons in the community, represent the classic implementation challenge. They require the long-term cooperation of multiple service bureaucracies and levels of government. What makes the task so hard—and what promises to test case management, special mental health authorities, and other current approaches in the mental health system—are overlapping issues of territoriality, resource supply, technical capability, and conflicting organizational objectives and styles (Dill & Rochefort 1989). In attempting to overcome these obstacles, mental health professionals and administrators confront the powerful force of tradition and an American human services apparatus built around the concept of dispersed responsibility.

Uncertainty about control and accountability in mental health care at the level of service delivery is matched by persistent ambivalence on these questions within government as a whole. Here, again, problems experienced by the mental health sphere reflect broader social policy dynamics of our federal political order.

The provision of public mental health services began as a local responsibility in the colonial era. With the spread of public mental hospitals in the 1800s, the task then shifted to the states. The Community Mental Health Centers Act of 1963 staked out a national interest in mental health care, one consciously designed to bypass the state role which was viewed as too tradition-bound for the necessary reforms. Roughly 30 years later, the Reagan administration's Alcohol, Drug Abuse, and Mental Health block grant decentralized administrative responsibility for this community mental health program to state officials. At the same time, however, the national government continues to seek to provide leadership—and a set of common priorities—in mental health policy through its ongoing work to bring psychiatric services in general hospitals into Medicare's prospective payment system, and through legislation to provide funding for such purposes as state mental health planning (Public Law 99–660) and services for the homeless mentally ill (Public Law 100-77) (Levine & Haggard 1989). It also exerts a massive indirect influence on mental health policy through general entitlement programs and the administrative regulations that govern these. A tangled, unresolved intergovernmental relationship results that makes it exceedingly difficult to develop rational or even coherent policy.

The low standing of mental health issues on the national social agenda poses another impediment to needed improvement of the mental health system. Except for brief interludes in American history, the mentally ill have not captured the serious attention of elected officials, who generally have little interest or knowledge relating to mental illness. The rule, instead, has been

neglect and a failure to appreciate the scope, severity, and degree of dysfunction and suffering associated with mental disorder. Chronically starved for resources and outside of public consciousness, the mental health sector persists as a kind of poor relation to other social commitments and without integration into the modern welfare state. It is significant that a recent comprehensive evaluation of the US social welfare system sponsored by the Ford Foundation did not even identify the mentally ill as a population of concern (Ford Foundation 1989).

Several factors account for this tendency toward exclusion. The expansion of social programs in the United States has followed a pattern of interest-group liberalism in which well-organized and visible clientele groups receive the most benefits (Lowi 1979). Lacking a mass membership and the resources this could provide, lobbying organizations for the mentally ill are a weak political force. The stigma of mental illness also limits the degree to which the general public is inclined to identify with this population. Further, mental health advocates have encouraged the separation of mental health and other social programs by stressing the unique plight of the mentally ill rather than the problems shared in common with other needy groups. The mental health constituency itself has been bitterly divided between diagnostic categories, advocates for children and adults, emphasis on varying priorities such as prevention versus care, and on medical-legal issues such as civil commitment policy. These divisions embody neither good strategy nor sound policy analysis, however. In recent years the emergence of the National Alliance for the Mentally Ill (NAMI) offers better prospects for effective interest group representation, but mental health advocacy continues to be fragmented and weak.

It is difficult to understand mental health policy outside of the large constellation of health and welfare entitlements whose gaps in coverage affect a variety of socially disadvantaged groups—the high prevalence of un-insurance for health needs and the lack of adequate affordable housing are just two examples. The severely mentally ill are multiply disadvantaged by poverty, disability, lack of housing and employment opportunities, and persistent social stigma. Public mental health care responsive to the needs of a de-institutionalized system requires coverage of this population within the entitlement structures on which their subsistence and welfare depend. This will require eliminating eligibility restrictions that discriminate against the mentally ill, and repairing the social "safety net" to make it truly comprehensive and reliable. Deinstitutionalization remains an unfulfilled promise. Having initiated policies that keep sick and disabled patients in the community, we require a framework of protections and supports to make the rhetoric of deinstitutionalization less a dream and more a reality.

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