American deinstitutionalization revisited

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How does the American history of deinstitutionalization compare with that in other countries? This question is difficult to answer, for the United States, on the one hand, excels in encouraging the development of innovative community-based treatment initiatives (Cohen, 1990; Talbott, 1981). Patients enrolled in «model» community mental health programs generally receive state-of-the-art services and almost certainly live more hopeful, more fulfilled lives than they might ever have done in hospital-oriented systems of care (Bachrach, 1989a). On the other hand, the United States suffers from a maldistribution of community mental health resources to the extent that some mentally ill individuals receive clearly inferior care (Lamb, 1993). Some, particularly those who are homeless, may get no services whatever (Bachrach, 1992b). The United States thus appears to specialize in extremes, as compared with other countries that strive to offer some, if not optimal, care to everyone (Bachrach, 1989b, 1991a, 1993c).

Moreover, there is a dearth of appropriate methodologies for comparative assessment. Although attempts are underway to facilitate cross-national comparisons (Knudsen & Thornicroft, in press; Leff, 1993), we are still in the process of developing reliable measures. Indeed, even making comparisons *within* the United States is a risky enterprise; for, in addition to a paucity of tested methodologies for comparing state systems, within-state local variations tend to be marked (Bachrach, 1991b).

Nor do the nuances of American health policy lend themselves to making summary assessments. The United States today has no federal agency that promulgates binding mental health policy or regulates mental health service delivery practices. States and local communities largely pursue their own priorities, a circumstance that makes it difficult, if not foolhardy, to generalize about American mental health care.

Yet it is critical that we attempt to evaluate the American experience with deinstitutionalization, for the history of that movement is both instructive and sobering (Freedman, 1990). Deinstitutionalization took root and grew during the 1960s, a time of vitality, humanism, and optimism in the United States. It stood alongside other civil rights protests of the day in supporting the rights of oppressed people, for there was widespread belief that community-based care would be more humane and more therapeutic than hospital-based care. Additionally, many early architects of deinstitutionalization anticipated that changing the major locus of service delivery would result in substantial cost savings (Bachrach, 1976, 1978).

So persuasive were the early advocates of deinstitutionalization that they were able to sustain a rare coalition of social reformers and fiscal reformers to support their cause. It became difficult — at times almost heretical — to find fault with an initiative with such broad-based appeal! Thus, in 1963, when John Kennedy challenged Congress to adopt a «bold new approach» in mental health service delivery, his ideas were enthusiastically received. The President's plea to downsize mental hospitals provided substance and direction for a trend that, thanks to the advent of psychotropic medications, was already underway in some parts of the country. Congress responded with enabling legislation and generous financial support, and a federal plan to replace psychiatric hospitals with a nationwide network of some 1500 community mental health centers was launched.

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Changes in the *zeitgeist*, however, as well as growing impatience over the lack of demonstrable evidence for the superiority of community-based care, weakened the deinstitutionalization movement and made it a vulnerable political target (Concannon, 1992). Only about half of the centers were funded and built before the federal program came to an end in the early 1980s. The individual states, not the federal government, assumed major responsibility for deinstitutionalization, and today community mental health facilities in the private and non-federal public sectors are among the most highly utilized psychiatric service sites in the country.

The effects of pursuing deinstitutionalization in the United States are dramatically reflected in service statistics. In 1955, the resident patient count in American state mental hospitals stood at a record high of 560,000. That number has declined in each successive year and stands today at 101,000, a reduction of 82%. Even more impressive is the drop of 88% in the resident patient rate, from 339 per 100,000 population in 1955 to 41 per 100,000 (Manderscheid & Sonnenschein, 1992).

These statistics are thrown into bold relief when we consider that there are, according to unpublished National Institute of Mental Health estimates, some 2.5 million long-term mentally ill people living in the United States. With only 101,000 enrolled in state hospitals on any given day, we may account for about 4% of the total. Of the remaining 96% there are substantial numbers whom we cannot locate, although many are surely in distress and in desperate need of help.

However, such gross statistics tell us little about the subtleties of American community mental health. Several broad observations may be made.

First, we may note that the American health care system does not, as currently configured, ensure the availability of mental health services to those in need. There are nearly 39 million Americans without health insurance of any kind (Pear, 1993); and even those who hold insurance frequently discover that psychiatric services are not included, or are severely restricted, in the coverage (Kessler, 1992; Sack, 1993).

Second, there are disparities between the ideology of community mental health and the actual implementation of deinstitutionalization plans. For the past three decades states have officially supported the principle that adequate community services should be developed in conjunction with the depopulation of psychiatric hospitals (Bachrach, 1976; Bradley, 1976). In reality, however, hospital services are often terminated long before adequate replacements have been supplied in the community.

Third, as noted, states and local communities vary in service delivery policies and practices. Some places, through determination, commitment, and tenaciousness, have developed extraordinarily effective community-based service systems. Other places, however, either unintentionally or by design, fail to provide even a minimum of sensitive and accessible care. The variables attending this uneven development are numerous and complex, but almost certainly include the presence of aggressive professional leadership and well-established cultural traditions of caring and reaching out to people in need — matters in which American communities exhibit striking differences (Bachrach, 1991b).

Fourth, it is possible to assess deinstitutionalization by several criteria, and the yardstick chosen will largely determine the outcome. From the point of view of progressive concept development and refinement, the United States has experienced substantial successes, as demonstrated in the evolution of such vital programmatic strategies as psychosocial rehabilitation, case management, outreach, and consumer involvement in service planning (Bachrach, 1992a, 1993a, 1993b; Cohen, 1990). However, from the perspective of tangible improvements in patients' well-being, the results of deinstitutionalization have at best been mixed (Lamb, 1993).

Fifth, the lack of consistency may be partially explained by the absence of a federal mandate for serving severely ill psychiatric patients in the United States. Without a binding federal policy, states and local communities are free to select whom they wish to serve and reject those patients they regard as «undesirable». This has led to «gatekeeping» practices in some communities, and to the exclusion, or extrusion, of some people from the system of care (Bachrach & Lamb, 1989).

Sixth, the absence of federal commitment and support is not, however, sufficient in itself to explain the negative outcomes that some communities have experienced. Some portion of the variance must also be explained by the fact that deinstitutionalization represents a journey through uncharted territory. American communities differ tremendously in the character of their target populations, the availability of financial and supportive resources for mental health programming, and the degree to which the local culture base supports community-based care (Bachrach, 1991b). Each deinstitutionalization

effort must go through a period of trial and error to determine which interventions will meet with success and which will founder.

In any case, even those nations that successfully promote universal access to mental health services experience problems in the implementation of deinstitutionalization efforts (Bachrach, 1991a; Bollini & Mollica, 1989; Crepet, 1990; Leff, 1993; Rule, 1989; Schmidt, 1992; Tansella, 1986, 1990; Thornicroft & Bebbington, 1989). Precisely why this is so is an intriguing question that merits serious consideration in view of vast differences in health care philosophies and service delivery practices. One may speculate that there are common issues in serving mental patients in the community that transcend national boundaries, and that these must be frankly examined for their broader implications.

Although some critics view American deinstitutionalization as a failure (Kiesler, 1992), such a conclusion is premature. Despite decades of experience, the ideology has not been given a fair chance to prove itself; for, in most of the country, the gap between philosophy and practice is enormous. We shall not know whether deinstitutionalization can succeed until we have discovered the means for eliminating this disjunction (Warner, 1989). What is needed in the meantime is, to some extent, self-evident. The United States must, as a nation, reconsider its responsiblity to mentally ill people and grant them access to the psychiatric and support service services they require. Psychiatric care must be afforded equal status with other health services in insurance blueprints. Communities that adopt punitive attitudes toward mentally ill individuals must somehow be persuaded that «madness» is not synonymous with «badness.»

This list continues. Mental illness must be destigmatized, and adequate resources channeled into humane and relevant service programs. Research utilizing both quantitative and qualitative methodologies must be supported to expand the knowledge base about what kinds of programming are best suited for what patients under what specific cultural circumstances (Bachrach, in press). Above all, the federal government must cease to be a non-player in the development and provision of services, and it must mandate sensitive and appropriate care for all who suffer from mental illness.

The prescription is a complex one, far more easily written than executed, particularly in today's climate of scarce resources and multiple competing service populations. Yet there is cause for optimism. The very fact that deinstitutionalization was historically endorsed and vigorously promoted in the United States, as witnessed by the developments of the 1960s, is testimony that America is capable of embracing compassion and change.

The United States is currently undergoing a major re-examination of its health care policies and practices (Bachrach, 1993c). As Americans experience the nation's first attempts to ensure global health care for all citizens, it is possible to hope that the promise of deinstitutionalization will be more widely realized. If and when the energy and optimism of the 1960s can be combined with three decades of experience in refining concepts of patient care, the United States will assume its rightful place as a leader in community mental health (Bell, 1993).

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