Prologue: The visibility of homeless mentally ill persons on the street corners of America serves us a poignant sign that U.S. mental health and housing policies are not meeting the needs of the nation’s most vulnerable citizens. Many observers have blamed the deinstitutionalization movement, which aimed to shift the mentally ill out of large public institutions and into the community for their care. In this paper, David Mechanic and David Rochefort take a hard look at the historical, social, and political context of deinstitutionalization and argue that many commentaries on the subject have oversimplified its impact. They suggest that many of today’s problems are dependent on changes in the welfare system and social conditions. A sociologist, Mechanic directs the Institute for Health, Health Care Policy, and Aging Research at Rutgers University and is René Dubos Professor of Behavioral Sciences there. He earned his doctorate in sociology from Stanford University and is a member of the National Academy of Sciences and the Institute of Medicine. Mechanic is currently involved in studying the consequences of deinstitutionalization, including increased dependence on specialized psychiatric units in general hospitals and the impact of such changes on patterns of care for the seriously and persistently mentally ill. A prolific and widely regarded writer, Mechanic last wrote for Health Affairs on the role of generalist versus specialist physicians in treating mental illness. David Rochefort is a health and social welfare public policy specialist who teaches in and chairs the public administration program at Northeastern University in Boston. A former postdoctoral fellow in the Rutgers-Princeton program for mental health research, he is currently engaged in a study of mental health policy under national health insurance in Canada. Rochefort received a doctorate in American civilization from Brown University, where he focused on policy studies.
In his essay, “On the Need for Asylums,” Lewis Thomas reflects upon the deinstitutionalization of the mentally ill, a massive nationwide effort that reduced the population of public mental hospitals from a peak of 559,000 in 1955 to less than 110,000 today. Thomas refers to deinstitutionalization as a calamitous “political side effect” of psychopharmacologic advances in treating mental disorders during the postwar era. Decrying the presence of mentally deranged homeless persons in the streets, the subways, and the parks of our major cities, he calls for restoring and improving the state hospital system. It is time to recognize, Thomas states, that deinstitutionalization “is not working.”

As do many commentaries on the subject, Thomas’s work greatly simplifies the impact of deinstitutionalization on mental health service delivery and on the community. The options for policy reform also are more complicated, and more hopeful, than an either/or choice between community and state hospital care implies.

Understanding deinstitutionalization of the mentally ill, one of the most far-reaching and vigorously debated social policy shifts of the past four decades, requires placing it in proper historical, sociological, and political perspective. By tracing how deinstitutionalization began and by describing the trends that mark its mature state, we can address the problems and possibilities facing mental health policymakers.

Roots Of Deinstitutionalization

Traditionally, care of the mentally ill has been a local responsibility. With population growth, urbanization, and industrialization in the late nineteenth century, states developed large mental hospitals to care for psychotic patients and others who exhibited bizarre behavior or had difficulty functioning in the community. Earlier mental hospitals were small, intimate institutions that tried to provide a humane, calm, and disciplined environment called moral treatment. But as the numbers of chronically ill, intractable patients increased throughout the late 1800s and early 1900s, mental hospitals became larger, more bureaucratic, and increasingly custodial. Mental hospitals became a facility of last resort for a variety of client populations for whom community alternatives were unavailable or unaffordable. The presence of increasing numbers of disabled elderly and patients suffering from the tertiary stages of syphilis and other debilitating chronic diseases made it difficult to maintain a hopeful, supportive hospital atmosphere. The burden of growing institutional populations on state budgets and the changing clientele, which included large numbers of disadvantaged immigrants, also led to the growth of impersonal custodial care.

By World War II, a variety of elements converged to set the stage for
major mental health reform. Psychodynamic perspectives contributed to a conception of mental illness as dysfunctional exaggeration of normal adaptations rather than as pathology arising from fundamentally different psychobiological processes. These conceptions were accepted, despite little evidence, and supported the emerging ideologies of prevention and social amelioration. The numbers of youth found ineligible to serve in the armed forces during World War II because of alleged psychiatric disability (almost 1.9 million between January 1942 and June 1945) together with frequent mental breakdowns seen during combat suggested the importance of preventive interventions. Pragmatic management of psychiatric casualties during the war also increased respect for psychiatrists and encouraged optimism about future strategies of community psychiatric care. As America emerged from the war, states sought ways to cope with the increasing financial burden from large psychiatric institutions. In 1946, Congress passed the National Mental Health Act, which established the National Institute of Mental Health (NIMH), with the intent of applying the public health approach to mental health and stimulating the development of community services.

In the middle 1950s changing administrative attitudes and the introduction of neuroleptic drugs created a new climate in large mental hospitals. Drugs helped to control bizarre manifestations of psychotic illness and gave administrators, hospital staff, and families increased confidence and hope. Security precautions were reduced, ward doors were unlocked, and hospitals became more receptive to discharging patients. In response to skillful lobbying by key advocates of the community care perspective, Congress passed the Mental Health Study Act of 1955, which endorsed the creation of the Joint Commission on Mental Illness and Health. Its final report in 1961, Action for Mental Health, set in motion a process that eventually led to the passage of the Community Mental Health Centers Act of 1963. During the 1950s and 1960s social research documented the devastating consequences of long-term custodial institutional care. Such studies contributed to making mental hospitalization less legitimate. In this process, and in the public debate that followed, there was little discrimination between good and poor hospitals. Also, the rhetoric of prevention in the 1960s arose from unproven premises that served as a basis for major changes in federal policy.

These varied influences were important factors leading to deinstitutionalization. But there were major barriers to locating appropriate residential settings for patients and enabling them to live successfully outside of hospitals. Exhibit 1 shows the dramatic course of deinstitutionalization. During the period 1955–1965, resident populations were reduced only 15 percent, from 558,922 to 475,202. Admissions, in contrast, increased over the same period from 178,003 to 252,202. This dramatic rise in admissions, in contrast, increased over the same period from 178,003 to 252,202. This dramatic rise in admissions...
316,664, resulting in a decrease of less than 2 percent in total inpatient episodes.\textsuperscript{8}

Between 1965 and 1975, resident patients in public hospitals decreased to 193,436—a reduction of almost 60 percent. Most important among the factors contributing to this decrease was the growth of welfare programs in the middle 1960s and early 1970s, such as Medicare, Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and housing subsidies. Medicaid, a jointly funded federal/state program of medical assistance for certain low-income groups, including the disabled, allowed states to shift half or more of their costs to the federal government by transferring patients from state mental hospitals to nursing homes. Charles Kiesler and Amy Sibulkin estimate that at least half (and probably many more) of the elderly discharged from public mental hospitals after 1964 were transferred to nursing homes.\textsuperscript{9} Nursing homes played a smaller but still significant role in the transfer of younger psychiatric patients out of state mental hospitals. Government programs that provided subsistence for patients living in community settings and made housing for them more feasible also expanded during the late 1960s and 1970s.

Legal activism on behalf of the mentally ill, which grew out of the civil rights movement, resulted in revised civil commitment laws that made involuntary hospitalization more difficult and in court rulings that enforced higher standards of care in public mental hospitals. This helped to motivate administrators to reduce inpatient populations to meet
expected standards. The number of public hospital residents thus continued to decrease, while admission became more difficult. By 1988, resident patients in public institutions had decreased 82 percent from 1955.

**Clarifying Misconceptions**

The critical role of non-mental health programs, such as Medicaid and SSI, is not the only important subtlety about deinstitutionalization that has often gone unappreciated. As Kiesler and others point out, myths, misconceptions, and ignorance are prevalent concerning the way deinstitutionalization actually took place and how a “deinstitutionalized” public mental health system operates. A few key facts elucidate this transformation of the U.S. mental health sector.

**Distribution.** Deinstitutionalization has taken place unevenly over different geographic areas. One of the pitfalls in thinking about deinstitutionalization is to view it as a unitary national phenomenon. Aggregate national trends hide considerable variation in deinstitutionalization’s timing and pace. The federal role in mental health care was limited before the 1960s) and states followed their own trajectories depending on local influences. Many factors affected state deinstitutionalization: (1) the size and configuration of a state’s facilities and the patient populations they contained, (2) fiscal arrangements such as cost sharing between state and community entities, (3) the political influence of the hospital bureaucracy within and outside state government, (4) the vigor of local community ideologies and demands for change, (5) the amount of strain faced by individual states from the “stagflation” of the 1970s) (6) the composition and advocacy of the local professional community, (7) the skill of state bureaucrats in shifting costs to federal and other budgets, and (8) the availability of alternative institutional services. Between 1967 and 1973, five states reduced inpatient populations by 20 percent or less, twenty-two states by 21 to 40 percent, and five others by 61 to 80 percent. Between 1973 and 1983, three states made no reductions or increased their inpatient populations, while thirty-five states decreased their inpatient populations from 41 percent to more than 80 percent.

Exhibit 2 shows state rates of deinstitutionalization between 1955 and 1973 (early) and between 1955 and 1986 (total). In the early phase, there was much variability, ranging from 14.7 percent in Nevada to 74.2 percent in California. The differential among states with the highest and lowest public hospital populations was large, with similar mean rates of deinstitutionalization among the large and small systems (57.7 percent versus 52.4 percent). By 1986, variation had been reduced, with rates of
### Exhibit 2
Reduction in Public Mental Hospital Inpatients, 1955-1986, Among States With Highest And Lowest Base Inpatient Populations In 1955

<table>
<thead>
<tr>
<th>States with highest number of inpatients in 1955</th>
<th>Number of inpatients</th>
<th>Percent decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>94,175</td>
<td>44,963</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>39,834</td>
<td>19,023</td>
</tr>
<tr>
<td>Illinois</td>
<td>38,001</td>
<td>10,373</td>
</tr>
<tr>
<td>California</td>
<td>36,482</td>
<td>9,419</td>
</tr>
<tr>
<td>Ohio</td>
<td>28,116</td>
<td>12,903</td>
</tr>
<tr>
<td>Illinois</td>
<td>23,471</td>
<td>7,842</td>
</tr>
<tr>
<td>New York</td>
<td>22,124</td>
<td>11,849</td>
</tr>
<tr>
<td>Michigan</td>
<td>21,249</td>
<td>7,563</td>
</tr>
<tr>
<td>Texas</td>
<td>16,553</td>
<td>9,937</td>
</tr>
<tr>
<td>Arizona</td>
<td>14,916</td>
<td>6,798</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>States with lowest number of inpatients in 1955</th>
<th>Number of inpatients</th>
<th>Percent decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nevada</td>
<td>416</td>
<td>355</td>
</tr>
<tr>
<td>Wyoming</td>
<td>639</td>
<td>304</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1,059</td>
<td>450</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1,232a</td>
<td>236</td>
</tr>
<tr>
<td>Idaho</td>
<td>1,247</td>
<td>270</td>
</tr>
<tr>
<td>Vermont</td>
<td>1,301</td>
<td>701</td>
</tr>
<tr>
<td>Utah</td>
<td>1,359</td>
<td>265</td>
</tr>
<tr>
<td>Delaware</td>
<td>1,414</td>
<td>1,169</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1,595</td>
<td>942</td>
</tr>
<tr>
<td>Arizona</td>
<td>1,755</td>
<td>779</td>
</tr>
</tbody>
</table>


dehospitalization relative to the base year ranging from 60 percent to 90 percent However, the difference in mean rates for the larger state systems for the period 1955-1986 compared with those of smaller systems increased—a difference of 7.4 percent. Two of the small systems added to their inpatient populations between 1973 and 1986. These data reinforce the importance of considering specific conditions in force within states for understanding existing variation. The fact that all states depopulated mental hospitals to a significant extent reflects the common influences of ideology, technology, and federal entitlements and
policies.

Role of CMHCs. Despite much rhetoric about their potential role, community mental health centers (CMHCs) did little to stimulate the depopulation of public hospitals. In line with their comprehensive service mission, CMHCs have a heterogeneous clientele, with many users not seriously mentally ill. William Gronfein examined the change in numbers of patients in state and county mental hospitals in each state between 1973 and 1976 in relation to the number of inpatient CMHC beds, outpatient hours, day-care hours, and the percentage of catchment areas in each state with operating CMHCs. He found that greater CMHC activity was significantly associated with less deinstitutionalization, contrary to general beliefs. One explanation he suggests is that when CMHCs had greater resources, they were less motivated and less willing to become involved with public hospitals and chronic patients. In contrast, Medicaid payments for nursing home care were correlated (.82) with public mental hospital inpatient decline for the period 1970 to 1975, controlling for state population size. These data by themselves cannot support a causal argument, but they are consistent with the view that funding incentives under Medicaid facilitated inpatient reductions.

Institutional care. Deinstitutionalization did not produce a noninstitutional mental health system. Although the number of persons in state mental institutions was greatly reduced, the mental health system today still relies substantially on different forms of institutional care for the seriously mentally ill. Nursing homes, as noted, have become a primary locus for the mentally ill; of the roughly 1.5 million nursing home residents in the United States today, estimates are that from 30 percent to more than 7.5 percent are mentally ill, depending on definitional criteria. Private mental hospitals have also increased in size and number, in tandem with the down-scaling of state facilities.

The most dramatic growth, however, occurred in the general hospital sector, now the major provider of acute psychiatric inpatient care. Supported by the expansion of public and private mental health insurance benefits, admissions to specialized psychiatric services of general hospitals rose to 877,398 in 1988, an 84 percent increase since 1969. Psychiatric admissions to general hospitals without psychiatric units brought the total to 1.56 million. An estimated 300,000 to 400,000 mentally ill persons live in nontraditional institutions in the community-halfway houses, board-and-care homes, and other community residences.

State hospitals. While the function of state mental hospitals has drastically changed over the past thirty-five years, such hospitals continue to provide a much-needed service within the overall mental health care system. States have needed to reserve a supply of public beds for intermediate and long-term psychiatric care and for patients
who are particularly difficult to manage in the general hospital sector due to their chronic conditions, legal status, or history of dangerous behavior. Consequently, even though state and county hospitals now account for a relatively small share of all inpatient mental health episodes each year, within the specialty mental health sector they are by far the largest provider of all inpatient days of mental health care, reflecting their clients’ longer lengths-of-stay (Exhibit 3).

Growth of the mental health system. Extraordinary growth of the mental health system coincided with deinstitutionalization. The number of patient care episodes in specialty mental health organizations went from 1.7 million in 1955 to 6.9 million in 1983.20 Community mental health centers, which did not exist before the mid-1960s, were treating as many as 3.3 million patients annually by the 1980s.21 Overall, Gerald Klerman has estimated a sixfold increase in the population’s use of mental health services in the twenty-five years following 1955.22 This

### Exhibit 3
Specialty Mental Health Sector Inpatient And Residential Treatment Days, Number And Percent Distribution, Selected Years, 1969-1986

<table>
<thead>
<tr>
<th>Type of organization</th>
<th>Thousands of inpatient days</th>
<th>1969</th>
<th>1975</th>
<th>1981</th>
<th>1986</th>
</tr>
</thead>
<tbody>
<tr>
<td>All organizations</td>
<td></td>
<td>168,934</td>
<td>104,970</td>
<td>77,053</td>
<td>83,413</td>
</tr>
<tr>
<td>State and county mental hospitals</td>
<td></td>
<td>134,185</td>
<td>70,584</td>
<td>44,558</td>
<td>39,075</td>
</tr>
<tr>
<td>Private psychiatric hospitals</td>
<td></td>
<td>4,237</td>
<td>4,401</td>
<td>5,578</td>
<td>8,568</td>
</tr>
<tr>
<td>Nonfederal general hospitals with psychiatric services</td>
<td></td>
<td>6,500</td>
<td>8,349</td>
<td>10,727</td>
<td>12,570</td>
</tr>
<tr>
<td>Veterans medical centers</td>
<td></td>
<td>17,206</td>
<td>11,725</td>
<td>7,591</td>
<td>7,753</td>
</tr>
<tr>
<td>Federally funded CMHCs</td>
<td></td>
<td>1,924</td>
<td>3,718</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential treatment centers for emotionally disturbed children</td>
<td></td>
<td>4,528</td>
<td>5,900</td>
<td>6,127</td>
<td>8,267</td>
</tr>
<tr>
<td>All other organizations</td>
<td></td>
<td>354</td>
<td>293</td>
<td>2,472</td>
<td>7,180</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent distribution of inpatient days</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All organizations</td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>State and county mental hospitals</td>
<td></td>
<td>79.4</td>
<td>67.2</td>
<td>57.8</td>
<td>46.8</td>
</tr>
<tr>
<td>Private psychiatric hospitals</td>
<td></td>
<td>2.5</td>
<td>4.2</td>
<td>7.2</td>
<td>10.3</td>
</tr>
<tr>
<td>Nonfederal general hospitals with psychiatric services</td>
<td></td>
<td>3.9</td>
<td>8.0</td>
<td>13.9</td>
<td>15.1</td>
</tr>
<tr>
<td>Veterans medical centers</td>
<td></td>
<td>10.2</td>
<td>11.2</td>
<td>9.9</td>
<td>9.3</td>
</tr>
<tr>
<td>Federally funded CMHCs</td>
<td></td>
<td>1.1</td>
<td>3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential treatment centers for emotionally disturbed children</td>
<td></td>
<td>2.7</td>
<td>5.6</td>
<td>8.0</td>
<td>9.9</td>
</tr>
<tr>
<td>All other organizations</td>
<td></td>
<td>0.2</td>
<td>0.3</td>
<td>3.2</td>
<td>8.6</td>
</tr>
</tbody>
</table>

Source: National Institute of Mental Health, Mental Health, United States, 1990 (Washington, DC.: U.S. GPO, 1990) 34, Table 1.5.

Note: In 1981, the federally funded community mental health centers (CMHCs) were combined with several other substance abuse programs to form the Alcohol, Drug Abuse, and Mental Health block grant. This led to a change in federal record keeping for the program.
enlargement, which occurred alongside deinstitutionalization, complicates any evaluation of the program’s impact. The need to accommodate new patient groups, many of whom never would have been candidates for state hospital admission in an earlier era, has been an independent force stimulating the shift to private and community-based services, irrespective of the deinstitutionalization movement.

**Problems In The 1980s**

Several factors combined in the 1980s to create a crisis in mental health services. Least anticipated within the mental health sector were the consequences of the changing demography of the American population, with large numbers of persons moving into age groups at high risk of mental illness. Schizophrenia and other major mental illnesses such as serious affective disorder and substance abuse commonly have their first occurrence in young adulthood. Given the demographic composition of the population, even if the incidence of disorder had remained unchanged, the prevalence of mental illness would have much increased.

**Changing demographics.** Morton Kramer, former head of NIMH’s Biometry Division, made extensive projections indicating increased service needs simply resulting from expected demographic changes, but these estimates elicited little interest and even less planning. For example, using census projections for the future U.S. population and specific age/ethnicity incidence rates for 1970 from the Monroe County, New York, Psychiatric Case Register, Kramer estimated incidence rates for schizophrenia between 1970 and 1985. Assuming no change in specific age/ethnicity rates, he projected a growth in new cases of 21 percent, including an increase of 43 percent among nonwhites. These increases were expected to vary by age group, with projected increases of 56 percent among whites ages twenty-five to thirty-four, and 87 percent among nonwhites of that age. These increases were, of course, far in excess of expected percentage increases in the U.S. population. Kramer made comparable estimates for the period 1980–2005, projecting continued large increases in prevalence rates of serious mental disorders, especially among the nonwhite population.

There is no evidence of growth in the incidence of schizophrenia, but changes in household structure, the increased use of alcohol and drugs, and resistant attitudes to care among younger cohorts exposed to anti-mental health ideologies have seriously complicated the management of many of these patients. A variety of data sets suggest the possibility of an increased incidence of affective disorders among the young. However, it remains unclear to what extent these findings can be explained by greater willingness among younger cohorts to recognize and report ad-
verse psychological states and to seek care. Similarly, many mental health service programs care for elderly patients with Alzheimer’s disease and other dementias—problems increasingly prevalent with the growth of the elderly population, particularly of those beyond age eighty who are more at risk. Based on growth in the population over age sixty-five, Kramer’s estimates project a 44 percent increase in the number of persons with senile dementia between 1980 and 2005.26

Expansion of welfare policies in the mid-1960s facilitated deinstitutionalization, but the contraction of these policies in the 1980s, when most patients were already in the community and there was little access to public mental hospital beds, pushed the problem into the streets. Medicaid failed to keep pace with growth of the poor population, and eligibility, scope of services, and reimbursement to providers were restricted. Similarly, escalating disability costs led Congress to require states to review SSI and SSDI awards, a process intensified by the Reagan administration.27 Between 1981 and 1983, half a million people lost benefits.28 Reviews of Social Security eligibility targeted younger recipients, disproportionately disenrolling mentally ill persons, who are on average much younger than those with chronic medical conditions. Several hundred thousand were reinstated on appeal, yet the loss of disability benefits created major difficulties in the mental health realm.

Housing. In the 1980s, housing opportunities shrank because of major cutbacks in federal housing programs, the gentrification of large city neighborhoods that housed the poor, and the loss of low-income housing. It was not until that decade, and the growing problem of homelessness, that mental health program administrators saw the need to develop appropriate housing for their client populations. By the middle 1980s, housing was seen as the single most critical issue faced by large city and state mental health authorities.29

The growth of homelessness, and the visibility of deranged persons on the streets, came to symbolize deinstitutionalization’s failure as social policy. Deinstitutionalization was never a planned and coherent national strategy, but rather a nonlinear, disjointed process featuring “loose coupling” of policies and results.30 It was often carelessly conceived and poorly managed, varying in focus depending on which state and local authorities were involved and the particular period under consideration. Much of what happened was inadvertent and unanticipated.

Public conceptions of the failures of deinstitutionalization are shaped by the media, which focus on the disorientation and pathetic situation of the homeless mentally ill in the nation’s largest cities—a depiction not representative of the country as a whole. The problem of homelessness is commonly attributed to depopulation of public mental hospitals; in fact, the long-term patients discharged were predominantly white and
middle-aged or elderly. Today’s homeless are a heterogeneous population with disproportionate numbers of young black males and a significant minority of young women who have children but are unmarried or have disrupted marriages. While some discharged long-term patients undoubtedly became homeless, the two populations are quite different.

Numerous studies suggest that for many, homelessness is a temporary state reflecting the precarious situation of the poor during times of economic adversity or changing housing markets. While the poor who are housed possess many problems characteristic of the homeless population, the homeless poor have personal and social histories that make them particularly vulnerable during economic downturns, such as disrupted households, mental illness, substance abuse, arrest and imprisonment, weak family and personal networks, and poor coping skills.

Estimates of psychiatric problems among the homeless vary by the populations sampled and measurement criteria, but all studies report high morbidity and considerable prior contact with the mental health system, relative to the population as a whole. Incidents of acknowledged prior hospitalization vary from 11 to 33 percent among the homeless, in contrast to 3–7 percent among general adult community samples. A study of the skid row homeless in Los Angeles using measures comparable to those of the NIMH Epidemiological Catchment Area Survey, which derived diagnostic judgments on the basis of interview responses, found that 60 percent of the homeless met criteria for a mental illness or substance abuse disorder—about three times the general population rate. Peter Rossi, summarizing twenty-five studies of the homeless, estimates that 27 percent have a history of at least some mental hospital experience; a combination of seventeen studies suggests an average rate of chronic mental illness of 34 percent. These figures exceed those of other poor populations who are also vulnerable to psychiatric problems.

The homeless with substance abuse and mental health problems have numerous unmet service needs, but the vast majority do not require long-term hospitalization. Most are able to live in the community with appropriate supportive services and only occasionally require hospitalization, much like other patients with many other chronic diseases. A study of homeless persons in Baltimore found that substance abuse disorders were particularly high (75 percent for men and 38 percent for women), although major mental illnesses were also prevalent. The psychiatric investigators assessed 18 percent of the men and 15 percent of the women as needing short-term or intermediate inpatient psychiatric care, but only 1 percent were appropriate candidates for long-term hospitalization. Furthermore, a study of men at initial entry into New York’s municipal men’s shelters indicated high levels of alcohol and drug abuse but fewer psychiatric problems. Only 17 percent were assessed as
having a definite or probable history of psychosis. Those who had a history of homelessness prior to entering shelter care had more psychiatric problems. Thus, it appears that the seriously mentally ill are more likely than others to remain chronically homeless.

That the homelessness problem evades an easy solution is well illustrated by the fate of policy actions undertaken by the administration of former Mayor Ed Koch of New York City. Koch mounted an effort in the late 1980s to remove the mentally ill from the streets involuntarily to give them needed medical and psychiatric attention. In so doing, city officials loosely interpreted state commitment laws by applying the criterion of being in danger of causing serious harm to oneself or others “within the foreseeable future,” rather than the standard legal test of “imminent danger.” In addition to stimulating numerous legal challenges by those committed—including the celebrated case of Joyce Brown, who won release when the court blocked city doctors from administering medication to her against her will—the program led to overcrowded municipal hospital units, long patient lengths-of-stay, and attempts by the city to transfer large numbers of patients to state facilities. The essential reason for the backup was the unavailability of needed services, primarily housing and supervision, to support the return of patients to the community.

Homeless persons are often disadvantaged by poverty, alienation from social bonds, substance abuse, and serious mental and physical illnesses. They need services that are either in short supply or unavailable. Very few of these patients require long-term hospitalization, but many require decent housing and appropriate mental health and alcohol and drug abuse treatment and rehabilitation. Hospitals are a form of housing, but at a prohibitive price for those who do not need these specialized environments. The cost of public hospitalization in New York exceeds $90,000 per person each year.

Estimating the costs of hospital and community care relative to benefits involves a variety of difficult methodological issues on what measures to include, the time span to consider for analysis, and indicators of costs and benefits. Burton Weisbrod and colleagues did one of the most systematic studies, comparing the experience of experimental and control groups in the Wisconsin Program in Assertive Community Treatment (PACT). They found that this intensive program cost somewhat more per patient than traditional care ($8,093 versus $7,269) but resulted in a somewhat superior cost/benefit outcome. The experimental program studied, however, was extremely service-intensive. Most cost/benefit comparisons find alternatives to mental hospitals far less costly, but these analyses typically lack the comprehensiveness and sophistication of the PACT evaluation. Hospital care, however, has
become highly expensive in most acute general hospitals and in many state systems. In most instances, very intensive outpatient services and related social and welfare services can be provided at lower cost, motivating the development of intensive case management programs. The challenge is to focus services on patients who will be high users of future inpatient care, a task that can be difficult.\(^{42}\)

### Current Issues In Community Care

Mental hospitals bring together in a single setting a variety of services needed by severely mentally ill persons, including housing, medical and psychiatric care, supervision, rehabilitative and other psychosocial services, and interaction with others. Such services for most patients can be provided in community settings that are less restrictive and preferred by most patients. Nevertheless, bringing these services together in dispersed community settings, particularly in large cities, requires a high level of coordination. In the community, responsibility for these services is widely diffused among multiple agencies with different missions, philosophical orientations, and varying appreciation for the special vulnerabilities of the mentally ill. Effective integration requires a strong organizational capacity, a clear focus of longitudinal responsibility, and the ability to control or guide available funds.

A number of randomized clinical trials and other studies consistently show that most organized alternatives to care in mental hospitals perform as well or better than inpatient treatment.\(^{43}\) The most successful programs involve aggressive psychiatric care and medication supervision, continuous treatment teams that are responsible for case management over the course of an illness, psychosocial training, activity programs, and help with housing and welfare entitlements. Most of these studies, however, have been carried out in communities where the challenges of coordination are not as formidable as they are in the nation’s largest cities. Some of these studies show that the severely mentally ill treated in aggressively organized care programs have fewer symptoms and better overall functioning and report a higher quality of life than those receiving more conventional hospital and outpatient care.\(^{44}\) Other studies of less well developed programs show that rates of hospital admission can be reduced without adverse effects but with little evidence of improved functioning.\(^{45}\) Sustained care over time is essential to maintain favorable results.\(^{46}\)

Despite thirty-five years of deinstitutionalization, programs providing alternatives to hospital care have developed slowly relative to the numbers of severely mentally ill patients residing in the community. As recently as 1986, 70 percent of state mental health agency funds, exclud-
ing Medicaid, were still allocated to state and county mental hospitals. If the federal, state, and local shares of Medicaid are included, the proportion decreases to 67 percent. Public hospitals administer outpatient programs in a variety of community settings, so the proportions may be somewhat exaggerated. Estimates are that about 5 percent of public hospital expenditures are for outpatient programs. Whatever the precise figure may be, however, there is no disagreement that expenditures of state mental health agencies are disproportionately at the hospital level, and that funds typically do not “follow the patient.”

A major challenge to state authorities is to shift expenditures from public hospitals to community programs. Such efforts meet resistance from unions representing hospital staff, from communities dependent on the economic base of the hospital, and from some patients’ families who support public long-term institutionalization.

If one is to rely on the general hospital sector to provide emergency and crisis response and short-term inpatient care, efforts are necessary to create stronger linkages between inpatient and outpatient care. Reimbursement in private health insurance and public programs provides strong incentives for inpatient care but little inducement for aftercare and rehabilitation that are often essential following discharge. Outpatient providers have little incentive to address needs of chronic patients covered by Medicaid, particularly when reimbursement has been low and noncompetitive. Medicaid patients also are often highly disabled and difficult to treat. A substantial proportion of Medicaid expenditures supports repeated short-term inpatient admissions without adequate outpatient follow-up. A New York State analysis found that only 30 percent of Medicaid patients discharged from hospitals with psychiatric diagnoses were linked to outpatient services within one month.

Three general strategies are now being tested for reducing the fragmentation of services and for creating systems that more clearly focus clinical, financial, and administrative responsibility for care. These include restructuring public reimbursement systems for mental health care, developing capitation programs, and organizing strong local mental health authorities that assume broad responsibility for meeting patients’ comprehensive needs over time. Within each strategy, a major goal is to develop vigorous case management approaches that coordinate care in ways that are responsive to patients’ needs across all relevant areas.

**Concepts Of Case Management**

The notion of case management has intuitive appeal; this approach is commonly suggested as the key solution to persistent problems of fragmentation. In practice, case management approaches are so diverse as to
give the designation little meaning. In some models, case management refers to a team of professionals, embedded in a coordinated system of services, that takes responsibility for managing the continuing mental health and other service needs of patients. These teams represent a range of professional competencies and authority to provide treatment directly or to link patients with other services. Some case managers, trained professionally in social work and psychiatric nursing, provide direct therapeutic services in addition to coordinating care; others’ roles are restricted to interfacing service systems. Common at the other extreme are nonprofessionals, with little specialized training, who make efforts to link patients to existing service systems and entitlements. These case managers typically are poorly paid, have low standing in the mental health system, and lack authority to direct or allocate resources. Their jobs are often temporary with no career structure and are characterized by high attrition. Case managers in poorly funded public agencies often face tensions between trying to serve clients and responding to administrative cost containment pressures.

Research on case management is not highly developed, but there is indication that when case management is simply grafted onto existing systems it may result in increased services and costs but uncertain benefits for patients in terms of improved quality of life. Results appear more promising when case managers operate as an integral component of a service system with clear responsibility and authority.

### Reimbursement Incentives

Strategies to change patterns of care typically involve the design of payment incentives to focus attention on high-priority objectives. The prospective payment system (PPS) under Medicare, which pays preset reimbursements based on diagnosis, is one such effort designed to induce hospitals to use resources more efficiently in providing general acute care services. Most psychiatric units have been exempted from PPS, however, although some states use per case payment to pay hospitals for psychiatric care. Some state mental health authorities are designing payment incentives to motivate providers to target selected patient groups and their special needs. New York, for example, is implementing a payment methodology for psychiatric care in general hospitals with specialized psychiatric units that pays more for serving priority populations such as the severely and persistently mentally ill and mentally ill children and for keeping inpatient episodes within specific length-of-stay intervals. Participating hospitals also receive increased payment for successfully linking discharged Medicaid patients to outpatient providers within ten days of discharge. Outpatient providers are rewarded for treating ne-
glected subpopulations of patients by being paid bonuses of as much as 40 percent for each unit of service provided during specified periods.

New York’s reimbursement modifications constitute one element of a larger strategy seeking to change the community care system. Other components include intensive case management for populations who use many hospital services, the development of new housing opportunities, and expansion of payment for community services including continuing day treatment, partial hospitalization, and intensive psychiatric rehabilitative programs. These initiatives, if effectively put in place, could reduce the number of inpatient residents in public hospitals and shift some of these patients to community care, potentially enabling very large savings in the institutional system. New York continues to rely heavily on its public hospital system, having had a rate of 124 inpatient residents per 100,000 population in 1986 relative to a national rate of 46.53 California, in contrast, had a rate of 19.5 and Wisconsin, 31.8. New York’s reliance on hospital care, highest among the states, contributes to the largest per capita mental health expenditure of any state.54

Capitating Mental Health Services

Mental health funding is fragmented among several payment streams, each with varying eligibility criteria and covered services. This situation makes it exceedingly difficult to manage and finance the care of patient populations with multiple service needs. Capitation is a payment method that establishes a fixed, predetermined price for each person covered for a specified range of services during a defined time period. Aggregating capitation payments over a large number of patients provides sufficient resources to develop needed services, and the fixed budget gives providers incentives to weigh the value of alternative types of services when providing care. Avoiding unnecessary hospitalization can redirect considerable resources to alternative services. Capitation is also appealing in that it establishes organizational responsibility for providing services to specified patients. In contrast to agencies such as CMHCs, which usually receive a fixed budget for serving their catchment areas and which can select their preferred clients, capitated programs have an obligation to serve patients enrolled in the plan.

Health maintenance organizations (HMOs) for mental health care, however, represent a form of capitation that differs greatly from HMOs in the general medical sector. The typical medical HMO serves diverse patient populations, some who need many services and others who need few or none, thus sharing risk among enrollees. In contrast, all members of capitated plans designed for the seriously mentally ill require substantial care. Thus, capitation is primarily a device to consolidate funding,
create service infrastructures, manage care, and direct care to specific target populations. Efforts to "mainstream" seriously mentally ill persons into traditional HMOs have faced major administrative obstacles, and many experts doubt that such mainstreaming can provide the level of services needed.\(^5\) Even a specifically organized mental health HMO involves risks of withholding necessary services because of cost considerations. The development of such efforts must be accompanied by appropriate quality assurance mechanisms.

Various localities have developed partial capitation programs for the seriously mentally ill. In an early effort in Rhode Island to close state hospital units, patients returning to the community depended on separately funded CMHCs to provide services they needed. The state allocated a budget for each of these patients. CMHCs that assumed responsibility thus received supplementary reimbursement for directing attention and resources to these typically neglected patients.\(^5\)

An ambitious capitation experiment in Rochester, New York, covers severely ill chronic patients who have a history of extensive use of psychiatric services.\(^5\) A nonprofit community service corporation, Integrated Mental Health Systems, receives state funding and contracts with CMHCs to provide care for designated patients on a fully capitated basis. Different benefit programs are provided for patients with varying mental health histories. In the intensive care category, the broad service program covers medical, dental, and psychiatric care; medications; and costs for community living, including housing if necessary. CMHCs, in addition, have incentives to garner entitlements for which these patients are eligible, such as SSI and SSDI. Patients in this capitation program are being monitored through a partial randomized experiment.\(^5\)

Early results show that among the most disabled patients, those selected for the program in both the capitation plan and the control group were expensive to care for, but much less expensive than patients outside the experiment who spent most of their time in the hospital.\(^5\) A key issue, however, is the selection differences between those enrolled and those not enrolled and whether it would be realistic to encompass such patients in a capitation plan.

Capitation is no panacea, but it offers a strategy for encouraging the development of services and managed care. Major barriers include finding the expertise and start-up funding to put such complex administrative systems into operation, the complex negotiations required with state and federal fiscal authorities and service providers, the difficulty of determining an appropriate capitation payment and establishing how risks will be apportioned, and the resistance of established groups such as unions, which feel threatened by the organizational changes and reduced reliance on state mental institutions.\(^5\)
Developing Local Mental Health Authorities

Complementary to aggressive case management and managed care approaches is a strategy to build strong entities at the local level that have administrative, financial, and clinical authority for managing the care of public patients, either directly or through contract. Such authorities could develop new services as needed, including housing options. A demonstration program, sponsored by The Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development, is in place in nine large cities for developing different local authority models. Evaluation is under way to examine how these structures affect the services system and patient outcomes.

Development of specialized mental health authorities is a formidable task affected by the social and political organization of the locality, the configuration of service providers, competition among various public and private agencies, and the attitudes of key political actors. It remains unclear whether the innovative infrastructures being tried will attain stability and whether they will have a sufficient impact on services to merit the prodigious efforts required.

The Future Of Deinstitutionalization

The processes set in motion by deinstitutionalization are unlikely to abate. Regulating bodies and courts have raised the standards for public mental hospitals, and there is less tolerance than ever for indiscriminate custodial care. State facilities also represent a major burden on state budgets, costing almost $5 billion in 1986 (excluding Medicaid). Under fiscal constraints likely to prevail, funding for community programs in many states will depend on further shrinking the public hospital system. New York, the largest system in the nation, reduced the number of resident patients in state hospitals by almost half between 1984 and 1991, and by 30 percent since 1987. The state mental health authority anticipates continuation of this trend over the next several years. Realizing the full advantage of this reduction requires closing some institutions, not simply down-sizing the system while keeping existing hospitals intact.

The debate over whether deinstitutionalization is a failure has become a sterile one, not least because the polemics outdistance the data. The question properly requires a multifaceted analysis. Of all patients ever discharged from public hospitals because of deinstitutionalization policies, and of all patients never admitted who would have been hospitalized under previous practices, how many are worse off and how many are better off? How much strain, economic and social, has deinstitutionalization...
zation placed upon the community, and how do we weigh the needs and wants of the mentally ill against those of the community as a whole? We have neither the information nor the normative framework to answer these questions definitively. But it simply is not sufficient to concentrate on the most visible deficiencies of deinstitutionalization, such as homelessness, and use them to generalize about the undertaking as a whole.

Finishing the task that has been started will not wait for resolution of such methodological and philosophical quandaries. There is little chance of a wholesale return to the public asylum at this point. There is need, however, to provide asylum to a small group of the most severely and chronically mentally ill, who are unlikely to ever make a comfortable adaptation to the community or who present persistent danger to society. Accordingly, future mental health policies must develop a comprehensive, balanced care system that links hospital and community services in a complementary fashion. A major obstacle is the traditional value placed on dispersed responsibility within American government. Multiple mental health and other service bureaucracies, operating at different levels of government, limit the coordinating attempts they inspire. One group of solutions, as discussed, pertains to the development of financial and organizational relationships with consistent incentives that discourage fragmentation. Another is to better integrate the mentally ill into programs of health and welfare entitlement in a manner that treats psychiatric disorder comparably to other illnesses. Differential treatment of mental illness in public and private health insurance programs has been a stubborn barrier to access to necessary services. For those most disadvantaged, repairing the “social safety net” to make it more reliable during misfortune should be a basic component of reform.

Political disadvantage generally accompanies social disadvantage; the plight of the mentally ill bears out this rule. Historically, the availability of high-quality, affordable mental health services has not been a high priority on the national agenda. This is no surprise to students of the American political system, who have long noted a pattern of “interest-group liberalism,” in which the greatest resources flow to the most organized and visible clientele groups. How much the situation will be modified by the recent emergence of skilled mental health constituency groups, such as the Alliance for the Mentally Ill, remains to be seen.

Arrival of the post-deinstitutionalization era in mental health care has been aptly announced. We are now enmeshed in a diverse set of problems focused on caring for chronically mentally ill persons, few of whom have been long-term hospital residents. Some scholars have proposed substituting the label “policies of inclusion” for “deinstitutionalization” to refer to the issues that are attendant on including the severely
mentally ill in society. The challenge of social integration is daunting, though not insurmountable, and tests the very credibility of the promise of the welfare state. Perhaps the only fundamental mistake of the deinstitutionalization movement was that anyone thought at the outset that this process of reform would be easy.

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NOTES


14. Gronfein, “Incentives and Intentions in Mental Health Policy.”


20. Ibid.


33. Ibid.

34. Rossi, *Down and Out in America*, 147, 154.

35. It is often assumed that mental disabilities among the homeless are a new occurrence, but, as Rossi has noted, mental illness, alcoholism, and physical disability were also very common among the homeless of earlier eras. Estimates of mental illness among the homeless in the 1950s and 1960s were in the range of 15 to 25 percent. These
somewhat lower estimates than the one-third typically reported at present may reflect
real differences or the expanding boundaries of mental illness definitions. See P.H.
Rossi, “The Old Homeless and the New Homelessness in Historical Perspective,”

36. W.R. Breakey et al., “Health and Mental Health Problems of Homeless Men and
1352–1357.


39. J. Rubin, “Economic Aspects of Mental Health Policy and Law,” in *Law and Mental
Health: International Perspectives*, vol. 5, ed. D.N. Weisstub (New York: Pergamon Press,
1990), 231–283.

40. B.A. Weisbrod, M.A. Test, and L.I. Stein, “Alternatives to Mental Hospital Treatment
II: Economic Benefit-Cost Analysis,” *Archives of General Psychiatry* 37 (1980): 400–
402.


42. W. Weissert, “Some Reasons Why It Is So Difficult to Make Community-based

43. For a summary, see Kiesler and Sibulkin, *Mental Hospitalization*.

44. L.I. Stein and M.A. Test, eds., *The Training in Community Living Model: A Decade of

45. M. Olfson, “Assertive Community Treatment: An Evaluation of the Experimental

46. L.I. Stein and M.A. Test, “Alternative Mental Hospital Treatment: I. Conceptual
Model Treatment Program and Clinical Evaluation,” *Archives of General Psychiatry* 37
Hospitalization in Schizophrenia: Five Years after an Experimental Program,” *American

47. These figures are computed from revenues received by state and county mental
hospitals from state mental health agency funds, Table 1.13, in *National Institute of
Mental Health, Mental Health, United States, 1990*, ed. R.W. Manderscheid and M.A.

48. See C.A. Taube, “Funding and Expenditures for Mental Illness,” in *Mental Health,
programs are confounded. Sixteen percent of community-based program expenditures
in 1985 were for inpatient care.

49. New York State Office of Mental Health, “ Consolidated Inpatient and Outpatient
Psychiatric Rate Methodology: Workshop Phase I Hospitals” (Unpublished document,

50. A.P. Dill, “Issues in Case Management for the Chronically Mentally Ill,” in *Improving
Mental Health Services: What the Social Sciences Can Tell Us*, ed. D. Mechanic (San


52. New York State Office of Mental Health, “ Consolidated Inpatient and Outpatient
Psychiatric Rate Methodology.”

53. *Mental Health, United States, 1990*, Table 1.21.

54. The figures vary by definition, but, however defined, New York’s per capita expendi-
tures are the highest of any state. See E.F. Torrey et al., *Care of the Seriously Mentally
Ill: A Rating of State Programs* (Washington, D.C.: Public Citizen Health Research
Group and National Alliance for the Mentally Ill, 1990); and National Association of State Mental Health Program Directors Research Institute, Final Report: Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results, Fiscal Year 1987 (April 1990).


56. D. Mauch, “Rhode Island: An Early Effort at Managed Care,” in Paying for Services, ed. Mechanic and Aiken, 55-64.


58. In this study, 40 percent of eligible subjects were prerandomized into capitation experimental groups and into control groups who received the conventional community care. Since the capitation program was optional, only half of the preselected experimental group enrolled prior to the end of the study, introducing significant selection biases.


