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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

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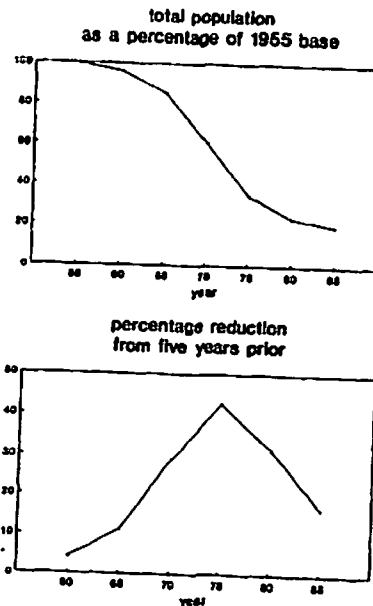


Figure 1 Resident patients in state and county mental hospitals: total population as a percentage of 1955 base and percentage reduction from five years prior

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 deinstitutionalization, 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.