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Deinstitutionalization (The Political Economy of Deinstitutionalization)

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Summary

Deinstitutionalization of chronically mentally ill persons in many western countries was initiated in the late sixties and early seventies of the last century, of course after the massive introduction of neuroleptics.

However in many countries the discharges of the inmates were made before community and local support network had organized satisfactory number of alternatives to host the discharged patients resulting to the negative phenomena of revolving door and homelessness.

On the other hand, Deinstitutionalization is directly linked with the welfare state and the adequate financial support of the programme. In several countries the sift from the welfare state to the market economy caused dramatic negative impact in the organization of the delivery of adequate mental health care for the vulnerable low socioeconomical class mentally ill individuals.

Deinstitutionalization was proven to be successful, when there where strong ideological or humanitarian motives and when psychiatric reform was a priority and was completed with a comprehensive system of community based alternatives and sufficient welfare support.

Introduction

To speak about deinstitutionalization of chronically mentally ill persons, the first thing that comes in mind is the genesis of the large psychiatric institutions, the Asylums, in the 18th century. The discovery of Asylum was a result of the archetypal fear against the inexplicable strange or ritualistic behavior, the unexpected episodes of violence and other inappropriate manners of some people, phenomena which have long been linked with the evil possession, according to Judaeochristian tradition (Rothman 1971).

The treatment of inmates in these Asylums was far beyond to be characterized as humane. The common features of "treatment" were restrictive measures such as chains, straw, filthy solitude in small cells, malnutrition provision of some empirical remedies such ipecacuana, tartarised antimony, syrup of buckthorn, valeriana, and other herbal "filters". Corporal punishment including flogging was commonly exercised. This was the state of "psychiatry" with the exception of some enlighten cases of humane care centers called by the historians as "moral treatment" places such as the York Retreat in England, the Bonifacio Hospital in Florence of Italy, the Hospitals of Bicetre and Salpetriere in Paris, the Bloomingdales Asylum in New

York. The situation in the large psychiatric asylums was remained unchangeable, although the majority of them were transformed around the middle of the 19th century into Mental Hospitals in many western countries (Mora 1975).

It took more than hundred years with several social, economic and political dramatic events and changes, including two catastrophic world wars, for the theoretical and practical negation of the asylum. It should be noted that in the 40's several inspired mental health professionals have applied an open door policy in their hospitals and have introduced innovative methods for the rehabilitation of the institutionalized patients including the concept of therapeutic community (Rothman 1971). The era of Social and Community Psychiatry was developed in the 60's and 70's in many western countries (Ralph 1983). It was of course the introduction of chlorpromazine and the other neuroleptics, which facilitated the opening of their gates (Mechanic 2007).

In USA the rates if mental hospitalizations per 100.000 of population declined from 400 per 100.000 in 1935 to 200 in 1970. The alternatives for the institutionalized life in the mental hospitals are now based in the Community with a variety of types of care such as Day Care Centers, Community Mental Health Centers, Vocational Rehabilitation Centers, Cooperatives and Social Firms, supported employment, Halfway houses, Social Clubs, Nursing Homes and Hostels (Mechanic 2007).

In the 70's the deinstitutionalization movement was grown in United States and in some European countries such as Italy, Great Britain, Sweden, France, Spain and others (Bachrach 1976, Madianos 2002). However, in many countries the massive discharges of chronically mentally ill individuals, were made before community and local support network had organized satisfactory number of alternatives to host the discharged patients (Mechanic & Rochefort 1990). The side effects of deinstitutionalization were the neglect of people with serious mental illness and phenomena of massive homelessness. The story behind was, the inadequate budgeting mainly in USA and in some other industrialized countries (Saraceno & Barbui 1997, Wave & Goldfingers 1997).

So it is the economy linked with the appropriate social welfare policy of the state, playing the major role in the effective deinstitutionalization and rehabilitation of the chronically mentally ill in the community (Thornicroft & Bebbington 1989).

Economy and mental illness

It has long shown that social and economic conditions are influencing psychiatric treatments and outcome.

Harvey Brenner's work has shown that Mental Hospital admissions in New York state especially for schizophrenia increased during the economic recession periods, although the annual expenditure of state Mental Hospitals did not decreased considerably (Brenner 1973).

It seemed that the lack of economic resources of families and the related support systems and the existing unemployment had influenced the course of illness, preventing recovery and causing relapses and readmissions. In the 30's Faris and Dunham in their ecological study in Chicago reported that the highest treated rates for

"Dementia Praecox" were concentrated in the slum areas of Chicago greater area (7 cases per 1000 adults in the slum areas to 2.5 per 1000 in the upper class areas). This study was replicated in several other cities of USA with the same findings (Faris and Dunham 1939).

In the 50's the classic study of Hollingshead and Redlich in New Haven, showed that lower income and social class patients had longer admissions to State Mental Hospitals and were more likely to be readmitted (Hollingshead and Redlich 1958). A decade later J. Myers and L. Bean found in New Haven again that lower class patients had longer length of stay in the hospitals and frequent readmissions and when they were discharged had poor work record and their living conditions were characterized by isolation and marginalization due to stigma (Myers and Bean 1968).

In another study by Astrachan et al. (1974) lower social class patients had more psychotic symptoms in a 2-3 years follow-up period after discharge from the Mental Hospital. Additionally, the prevalence of stressful life events are more frequent in the lower class populations and consequently the stress diathesis risk for a schizophrenic episode is increasing (Yanos et al. 2001).

Some other studies pointed out the harmful effect on mental health from other phenomena related to economy, such as unemployment, community's economic hardship and social disruption as well as criminality and violence (Wave and Goldfingers 1997, Saraceno and Barbui 1997, Wilton 2007).

Deinstitutionalization, Psychosocial Rehabilitation and the globalization of the economy

The relationship between the economy and the effective psychosocial rehabilitation needed for the deinstitutionalized patients has already been proven. For example, work is a basic rehabilitation goal, and obtaining a job (full or part time) is always a desirable ambition. The question is how to get a job when the economy is in recession and unemployment rates are high. In most Western states, economic recession is a chronic phenomenon. This could cause difficulties even to supported employment programs (Drew et al. 2001). Moreover, the economic recession is always linked with psychosocial programs budget cuts.

Globalization of economy has brought serious economic changes (market economy), increasing unemployment rates (investments are moving to cheap labour countries), privatization of social institutions (less social welfare state), high social mobility, transformations in the family structure, and marginalization of socially disadvantaged groups (e.g., unskilled workers, minority groups and disabled persons) (Morrow 2004, Madianos 2006). The marginalization-alienation of the less economically advantaged social groups including the mentally disabled in the metropolitan areas of western countries increases the risk for developing a mental disorder of worsening the existing one (Williams et al. 1973).

The growing economic insecurity causes a considerable emotional and economic burden especially to families with a member suffering from serious mental illness. These families are often facing profound economic hardship (Madianos et al 2004, Schene et al. 1998). Poverty has a significant negative impact on psychological well-

being, self-esteem, health (physical and mental) and the quality of life in general. Particularly low levels of quality of life in its various domains (social relations, leisure activities, nutrition, housing) are experienced by individuals suffering from serious mental illness and their family members (Wilton 2004).

Poverty and the development of mental health care and rehabilitation services in the world

In the new millennium, the majority of the countries of the world, belong in the category of lower or lower-middle level of economic development. This social and economic condition is reflected in the existing of mental health care and psychosocial rehabilitation services. On the other hand, the increasing incidence of mental disorders are imposing a great global burden (Murray and Lopez 1996).

From the WHO Mental Health Atlas we could observe dramatic discrepancies in the existence of community based mental health services and the specialized services for chronically mentally ill (rehabilitation services) (WHO 2000, 2001 a, b, 2005).

Table 1. Distribution of the countries of the world according to their economic level and the existence of community based psychiatric services, disability benefits and specialized services for chronically mentally

Economic level of countries based on GDP (2004)	Existence (%) of community based psychiatric services	Existence (%) of Disability Benefits Policy	Existence (%) of specialized services for chronically mentally ill patients
1 Lower	51.7	55.2	55.2
2 Lower-Middle	51.9	88.7	44.4
3 Higher Middle	90.9	78.8	72.7
4 Higher	97.4	100.0	86.8

Source: WHO Mental Health Atlas 2005

Only half of the lower economically developed countries, provide community based psychiatric services, disability benefits and rehabilitation services contrasting with the 97.4% to 100% of higher level of economically developed countries, providing the previously described services.

Table 2. Distribution of median cost for maintenance treatment with Chrorpromazine 400 mgr of psychotic disorders per patient by the level of economic development of countries.

Economic level of countries based on GDP (2004)	Median cost in USD
1 Lower	47.89
2 Lower-Middle	35.84
3 Higher Middle	108.62
4 Higher	155.200

Source: WHO Mental Health Atlas 2005

In table 2 the median cost of maintenance treatment of psychiatric disorders with 400mgr of Chrorpromazine, is positively correlated with the economic level of the countries.

Table 3. Availability of specialized mental health programs for children and elderly persons by the level of economic development of countries.

Economic level of countries based on GDP (2004)	For Children	For elderly
	Countries %	Countries %
1 Lower	34.5	17.9
2 Lower-Middle	73.6	50.9
3 Higher Middle	72.7	66.7
4 Higher	86.8	89.5

Source: WHO Mental Health Atlas 2005

Finally, in the table 3 the economic level of the county is definitively related with the development of specialized services (rehabilitation etc.) for children and the elderly. In the category of lower economic level countries, only 34,5% and 17.9% of the countries provide these services for children and elderly respectively compared to that of 86.8% and 89.5% of the rich countries which provide these services respectively.

There are also other significant findings such as the percentage of the total health budget spent on mental health to be 0.5 to 1.2% in low-income countries, 2.8% in middle-income countries and 6.9% in high-income countries. The shortage of mental health personnel (psychiatrists, psychologists, social workers, psychiatric nurses etc.) is profound among the low income countries (Saraceno and Barbui 1997).

However, in many of the low income countries family and community support systems still exist protecting the suffering from mental illnesses members (Jablensky et al. 1992, Mc Kenzie et al. 2004).

The other side of relationship of economy and mental illness in the era of globalization is the social correlates of the deinstitutionalization movement in the

developed countries (Williams et al. 1973, Scull 1985, Thornicroft and Bebbington 1989).

Moreover, the ongoing process of deinstitutionalization of long-stay inpatients in many western countries are more involving the family and the community. When the family and the local community are economically disadvantaged are unable to accept the deinstitutionalized patients, these patients are likely to become homeless, or trans-institutionalized. In these cases psychosocial rehabilitation sounds ironic.

Political economy of deinstitutionalization

Deinstitutionalization apart from the theoretical negation of the asylums incorporates the cost-benefit factor for discharging chronic inmates into the community, given the fact that the majority of them belong to lower middle or lower socioeconomic class (Bachrach 1976). In the middle of the 70's when N.I.M.H. in USA initiated the nation-wide program of closing down the State Mental Hospitals, the first President's (Jimmy Carter's presidency) the Commission on Mental Health focused on the development of specialized programs for the discharged patients. However, when Ronald Reagan took over the Office in 1981, the mental health policy was not a federal priority, with serious budget cuts, and blocking of grants. In this period in USA Medicaid, Supplemental Security Income and Section 8 housing, covered poorly the unmet needs of chronically mentally ill. In the same time period, consumers in USA were organized under the frame of the National Alliance for the Mentally Ill fighting for the protection of their rights (Mechanic 2008).

In the 90's in USA in an attempt for controlling the various treatment and care expenses, it was created the Managed Behavioral Health Care (MBHC) for both private and public sectors. MBHC avoided hospitalizations and reduced length-of-stay. In the case of chronically mentally ill individuals MBHC is a problematic approach of care because severe mental illness often require specialized services with high intensity not provided by this system (Mechanic 2008).

Deinstitutionalization is a multifunctional process to be viewed in a parallel way with the existing unmet socioeconomical needs of the persons to be discharged in the community and the development of a system of care alternatives (Mechanic 1990, Madianos 2002).

Schizophrenia on the other hand, a diagnosis of which the vast majority of deinstitutionalized patients are suffering, is in many cases debilitating illness resulting significant economic burden. In the United States the overall 2002 cost of Schizophrenia was estimated to be $62.7 billion with $ 22.7 billion direct health care, cost ($ 7.0 billion for outpatient, $ 5.0 billion for drugs, $ 2.8 billion for inpatient treatment and $ 8.0 billion for long-term care) (Wu et al. 2005). The total direct non-health care excess costs, including living cost, were estimated to be $ 7.6 billion and the total indirect costs were estimated about $ 32.4 billion.

Similarly, in neighboring Canada the direct health care and non care costs for the estimated numbers of persons with Schizophrenia (n: 234.305) were estimated to be 2.02 billion CAN dollars in 2004. This combined with their high unemployment rate and loss of productivity and higher mortality and morbidity rates, resulted an estimate additional cost of 4.83 billion CAN dollars (Morrow 2007).

In Australia the estimate of the annual cost of psychoses is about 2.25 billion Australian dollars (Neil et al 2003).

The above economic figures are showing that Schizophrenia affecting hundred thousand persons, the majority of them been deinstitutionalized, has a high economic burden requiring serious allocation of resources not a simple hospital beds reduction policy and letting these persons in their fate in the community. Some studies have shown a negative correlation between reduction of hospital beds and excessive mortality rates (Saha et al. 2007). The neglect of such persons is reflected in their increased mortality and morbidity rates. People with chronic mental illness die on average 20-25 years earlier than the general population (Parks et al. 2006).

Several studies document there is a serious public health problem for the people underserved by the mental health care systems (Yanos et al. 2001). The majority (60%) of the premature deaths are due to medical conditions (usually preventable), such as cardiovascular, pulmonary and infections diseases. Another 30-40% of mortality is due to suicide, injuries, and accidents. Among these persons, natural causes of death are cardiovascular disease, complications from diabetes and metabolic syndrome, respiratory disease due to heavy smoking, and infections including HIV/AIDS and tuberculosis. Tuberculosis was found to be frequent among residents in group homes and homeless shelters. Serious health problems are associated with malnutrition, obesity, lack of exercise, excessive alcohol consumption, and unsafe sexual behavior. The relative risk of cardiovascular disease is 2 times for persons suffering of schizophrenia due to excessive obesity, 2-3 times for smoking, 2 times for diabetes and 5 times for dyslipidemia. An 18-20% of these persons are suffering from hypertension. It is a common finding that persons with serious mental illness often lead a marginal living in the poor areas of the urban centers, in conditions of low quality, having unhealthy habits, high rates of substance use, being often victims of violence and theft with little access to all forms of health care because of their lack of motivation, fearfulness and social instability and due to competing demands and stigma by the providers and fragmentation of the health-mental health care system (Wilton 2004).

Conclusions

It becomes apparent that deinstitutionalized persons with serious mental illness in many western countries are vulnerable to a series of health and social problems and are facing significant difficulties in the accessibility of health care services. In the USA people with serious mental illness due to their social class condition, are addressed to under-funded publicly supported health-mental health care systems trying to overcome a number of obstacles, such as lack of reimbursement for health education and family support, inadequate and under-shilled case of management services, poor coordination between services and lack of integrated treatment for co-occurring psychiatric and substance abuse disorders.

Finally, the phenomenon of transinstitutionalization complements the policy of deinstitutionalization. In the USA there are about 200.000 incarcerated persons with serious mental illness in state or country prisons.

Last but not least, deinstitutionalization was often linked with community's reaction and negative attitudes, prejudice, stereotypes, stigma and discrimination against the community placement of persons with serious mental illness (Matschinger and Angermeyer 2004). However, stigma and negative attitudes can be changed if appropriate systematic community mental health intervention efforts are made (Madianos et al. 1987, Madianos et al. 1999).

In sum, several political and social economical motives were behind the movement of deinstitutionalization in western countries.

- Ideological: the case of Italian reform (Warner 1994).
- Economical: cost savings and the value of Asylum buildings, the case of USA and Great Britain.
- Humanitarian: concerns for the liberation of inmates, the case of France, W. Germany, Spain, Greece and other European states (Madianos 1994).

Particularly in Italy deinstitutionalization became synonymous to the ideology of "Psychiatria Democratica" with echoes from May 1968, and the closure of all public mental hospitals. In Greece, Spain and some other European states the Psychiatric reform was the first priority before the opening of the gates of large psychiatric hospitals (Madianos 1974, Madianos and Christodoulou 2007). In USA deinstitutionalization was forced in an inadequate milieu of alternatives, putting the inmates in their fate, resulting the phenomenon of revolving door and homelessness in urban centers. There are now about one million homeless chronically mentally ill persons in all the major cities of USA.

In those countries deinstitutionalization was proven to be successful when psychiatric reform was a priority and was completed with comprehensive system of community based alternatives and sufficient welfare umbrella. This means that the process of deinstitutionalization is step by step multidimensional and consumer centered. Deinstitutionalization encompasses the individual's whole life needs, including continuity of treatment (health and mental health care) housing, employment, education, community support system and complementary services (athletics, recreational etc.). If family exists, the state alleviates the burden of care. The final goal is the community autonomous tenure of the suffering individual and his/her integration, in a status of full social and clinical recovery.

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