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Updated June 26, 2018

Psychiatric Institutionalization and Deinstitutionalization

The history of mental health care in the United States can be understood as a period of institutionalization followed by one of deinstitutionalization. Federal law, however, has not been fully aligned toward either institutional care or community-based (i.e., noninstitutional) care.

Institutionalization

The early U.S. health care system offered little treatment for mental illness. People with serious mental health conditions often ended up in prisons or shelters for the poor. Few privately or publicly funded asylums had been established by the mid-19th century, when state psychiatric hospitals began to grow in number and size. Institutional mental health care was viewed as a state responsibility and was not funded by the federal government. Community-based (i.e., noninstitutional) mental health care was mostly unavailable.

Even as institutionalization was on the rise, the foundations for its decline were emerging in the form of perceived problems with institutional care and benefits of community-based care. Stories of poor living conditions in psychiatric hospitals raised concerns about the well-being of their patients. During World War II, psychiatrists began to forego or shorten hospitalizations as they learned that patients fared better when rapidly reintegrated into their social milieu. Approval of the first antipsychotic medication (chlorpromazine) in the 1950s made community-based treatment of mental illness seem more feasible. These developments set the stage for the decline of the asylum.

Deinstitutionalization

The number of beds in state and county psychiatric hospitals declined by more than 90% from 1955 to 2005 (per HHS Publication SMA 09-4424). The shift from institutional care to community-based care was influenced by several social movements (see **Table 1**) and developments in two areas of federal policy (see **Figure 1**): grants supporting community-based services and Medicaid coverage for Medicaid-eligible residents of institutions for mental disease (IMDs).

Also of note, a 1999 Supreme Court decision further encouraged deinstitutionalization. *Olmstead v. L.C.* involved two women with mental illness and developmental disabilities, each of whom remained confined in the psychiatric unit of a state hospital for several years after clinicians determined that her treatment needs could be met by community-based care. The Supreme Court held that unjustified segregation of persons with disabilities violates the Americans with Disabilities Act (P.L. 101-336) and that public entities must provide community-based services to persons with disabilities when such services (1) are appropriate, (2) are acceptable to the affected persons, and (3) can be reasonably accommodated.

Table 1. Social Movements and Deinstitutionalization

The *civil rights movement* of the 1950s and 1960s advocated for more humane care than was being provided in mental institutions.
The *community mental health movement*, which began in the 1960s, supported community-based mental health programs, which later narrowed their focus to individuals with long-term illnesses.
The *evidence-based practice movement* of the 1980s and 1990s (with roots dating back to the 1960s) advocated the use of treatments supported by research findings.
The *recovery movement* applied the principles of the consumer movements of the 1980s and 1990s to mental health care.

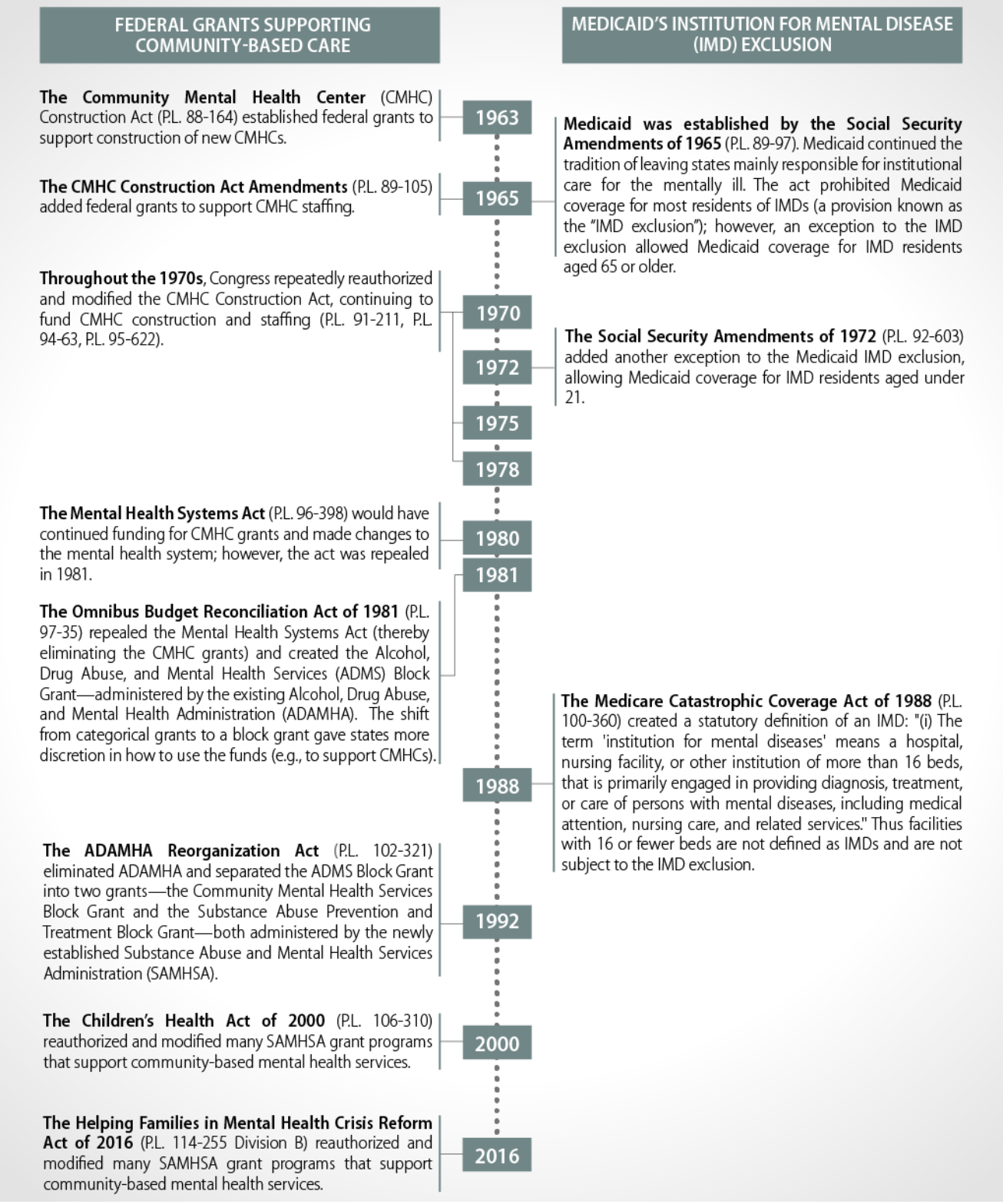
Sources: Testa and West, "Civil Commitment in the United States," *Psychiatry*, vol. 7, no. 10 (2010), pp. 30-40; and Drake and Latimer, "Lessons learned in developing community mental health care in North America," *World Psychiatry*, vol. 11, no. 1 (2012), pp. 47-51.

Recent Developments

Stakeholders continue to debate the best balance of institutional and community-based services. Most agree that the supply of psychiatric beds in hospitals is not adequate to meet the demand for institutional care. Some argue for more psychiatric beds to meet the demand; others argue for more community-based care to reduce demand for psychiatric beds by preventing mental health crises. Policymakers have pursued both paths—increasing options for Medicaid coverage for residents of IMDs and creating incentives for community-based mental health care.

- The Demonstration Programs to Improve Community Mental Health Services support participating states in certifying community behavioral health clinics meeting criteria related to quality of care; the demonstrations (which were authorized by P.L. 113-93) are underway.
- In July 2015, the Centers for Medicare &Medicaid Services (CMS) informed states that they could pursue Section 1115 waivers to receive federal Medicaid payments for coverage of substance use services provided to nonelderly adults in IMDs.
- In April 2016, CMS issued a rule that clarified a Medicaid managed care option to fund behavioral health services in an IMD services with a 15-day per month limit.
- The Helping Families in Mental Health Crisis Reform Act of 2016 (P.L. 114-255 Division B) reauthorized and modified many grant programs that support community-based care; most are administered by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Figure 1. Selected Federal Laws (1955–2018)



Source: Congressional Research Service. Figure created by Jamie L. Hutchinson, Visual Information Specialist.

Notes: For more information about SAMHSA-administered grants supporting community-based mental health services, see samhsa.gov/grants. For more information about Medicaid's IMD exclusion, see CRS In Focus IF10222, *Medicaid's Institutions for Mental Disease (IMD) Exclusion*.

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IF10870

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