Deinstitutionalisation of the Welfare State; the
Case of Mental Health Care
by
Rachel A. Hennessy

Thesis submitted to the Faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of
Master of Arts
in
Political Science

APPROVED:

Richard Rich, chairman

Sara A. Rosenberry  Michael Hughes

December, 1986
Blacksburg, Virginia
Acknowledgements

I would like to thank the members of my committee for the assistance and encouragement they have given me. In particular for their patience in waiting for a final draft. I would also like to thank Dan Guerrant for proof reading. Finally, I would like to express my gratitude to the Political Science Department of Virginia Polytechnic Institute and State University for giving me this opportunity to study and live in the United States.
Preface
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Critique of existing theories</td>
<td>3</td>
</tr>
<tr>
<td>Marxist theory and social policy</td>
<td>9</td>
</tr>
<tr>
<td>Comparative perspective</td>
<td>16</td>
</tr>
<tr>
<td>Issues</td>
<td>16</td>
</tr>
<tr>
<td>Dimensions of Comparison</td>
<td>18</td>
</tr>
<tr>
<td>Indicators</td>
<td>19</td>
</tr>
<tr>
<td>Sources</td>
<td>19</td>
</tr>
<tr>
<td>Findings</td>
<td>21</td>
</tr>
<tr>
<td>Health system</td>
<td>21</td>
</tr>
<tr>
<td>Mental health policies</td>
<td>24</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>24</td>
</tr>
<tr>
<td>United States</td>
<td>26</td>
</tr>
<tr>
<td>Finland</td>
<td>28</td>
</tr>
</tbody>
</table>
Historically the mentally ill have been segregated from the general population in large, geographically isolated hospitals. In recent years there has been a tendency towards a policy of short term admissions and treatments and a closing down of the chronic wards. The ultimate aim being to return and keep the mentally ill in the community. This shift in policy is evident in Western Europe and the United States.

Justifications for this reversal of policy usually focus on the three issues: humanism, that keeping the mentally ill in the community is a kinder way to treat people; effectiveness, that it is a more suitable way of re-habilitating them; and efficiency, it is cheaper than institutional care.

This thesis seeks to examine these claims using secondary evidence. There is massive ignorance about what community treatment is or even about the effects of abandoning the institutional structures. Similarly the claim that it is cheaper is just that- a claim. Many of the problems of returning the mentally ill to the community were not foreseen. Certainly not that the consequences for many of them in the community, may be homelessness, and criminalisation. When these and other costs of abandoning the hospital structure are considered, the conventional explanations are not so convincing.

It is not the purpose of this study to advocate reinstitutionalisation. But rather to analyse recent trends from a political-economic perspective. It is the main contention of this study that an adequate understanding of how, why and to what effect different countries pursue particular policies must stem from a structural analysis of the role of the state and social policy. I will ask the questions: what were the functions of the mental hospital in developed societies; what changes in the economy or conflict of groups caused their demise; what alternatives are proposed; and finally what are some of the problems with a move to the community.

For the purposes of this study I will use a definition of deininstitutionalisation proposed by Bachrach 1976. Bachrach specifies this policy as involving two elements.
• The eschewal of traditional institutional settings - primarily state hospitals - for the care of the chronically mentally ill; and

• the concurrent expansion of community based services for the treatment of these individuals.

There are actually two sides to the emptying of hospitals: the transfer of people who have already been hospitalised from their institutional setting into the community, and the prevention of hospitalisation of those who might otherwise be considered candidates for institutionalisation (Bachrach, 1976 p.1-2).
Introduction

This study focuses on the mental health policies in four countries; Denmark, Finland, United Kingdom\(^1\) and United States. Discussion is largely limited to the issues of the last thirty years and in particular the policy of deinstitutionalisation. The entry of political theory into discussion of alternative mental-health systems may seem like an illicit intrusion, founded primarily in "grand theory" (Wing, 1981). But the approach taken here is that theory provides the basis for understanding the policy change.

Critique of existing theories

Recent trends from hospital to community-based services, in the United States, have been explained by reference to a number of different factors.

The changes are primarily the consequence of the success of pharmacologic agents, new forms of psychotherapy, changing attitudes of the public, and increased financial support by the government.

\(^1\) The United Kingdom includes: England, Wales, Scotland and Northern Ireland. But for the purposes of this study I will only mean England and Wales as they are under the one health jurisdiction, whereas Scotland and Northern Ireland have their own health organisations and policies.
While case studies such as these are a useful source of detail, their use in theory building is limited. The main problem as Feldman sees it, is that without a guiding theory explanation for policy becomes lists constantly awaiting addenda, comparative cases hover close to the line of anecdote.

(1978, p.300)

The first factor, may be labelled the "technological" explanation. It is argued that the psychoactive drugs were a kind of "miracle drug" that eradicated the worst symptoms of mental disease and led as a direct result to a reduction in the duration of stay and to an increase in patients discharged from hospital. The new drugs were considered revolutionary as up to that point, effective treatment for the mentally ill was virtually unknown. This explanation of the changing trends in mental health policy is one favoured in government and medical circles. In 1959, English medical authorities had reported that, "the modern physical treatments and the new tranquillising and stimulating drugs...explain why with a rising admission rate the number of mental patients has now dropped each year since 1955" (Chief Medical Officer's report, 1959, p.128). In the United States, psychiatrists on the American Joint Commission observed: "Tranquillising drugs have revolutionised the management of psychotic patients in American hospitals, and probably deserve primary credit reversing the upward spiral of the State hospital in-patient load" (U.S.Joint Commission, 1961 p.39).

While new technology is likely to have been crucial in creating the conditions for change, it is not sufficient to explain the variation in the timing of the rundown of institutional populations of western societies. Were the switch to community care simply a response to the availability of new technology, one would expect to see a close similarity of discharge patterns. In fact the reverse is true: while Britain and the United States drastically reduced their in-patient populations in the 1950's, elsewhere in Western Europe (e.g. Finland and Germany) the mental hospital populations continued to grow. Even if contradictory evidence were not available, the acceptance of such an

---

2 Sedgewick, 1982 p. 198. observes, Most damaging of all to the view that these new medications constitute a collective miracle drug which...enables large-scale discharges into the community to take place as a direct result of their chemical action... is the relatively late point (1970's) at which the in-patient numbers in French hospital began to dip...It should be noted chlorpromazine (Largacil), the most prominent of the new tranquillisers, had actually been first developed in France in December 1950, by the pharmaceut-
explanation couched simply in terms of pharmaceutical progress would imply the acceptance of a naively deterministic theory of the relationship between technological progress and social policy making. There is no reason why in other contexts this new technology, the so called “chemical strait-jacket”, could not be used within the hospital setting, a more subtle means of control than physical constraint, but having no effect on discharge rates.

By way of contrast, a second explanation emphasises the subjective content of policy; the role of people in defining problems, and their values and responses to them. “Mental health reformers have played a crucial role in identifying the problem, posing policy solutions, monitoring programme implementation and suggesting further initiatives to improve programmes.” (Armour, 1981, p.10). In the 1960’s, sociologists and psychiatrists described the pathological effects of institutionalisation. Perhaps most famous was Erving Goffman’s “Asylums” (1961). Goffman defines the mental hospital as a “total institution”, that is;

\[
\text{a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead a formally administered round of life. (Goffman, 1961 p.11).}
\]

The alienation from society and the unwillingness to leave the hospital, is observes Goffman, “a side effect of hospitalisation that frequently has more significance for the patient and his personal circle than do his original difficulties (1961, p.310). Macmillan and Rees, pioneers of the ‘open doors’ policy in Nottingham, England, believe that, ‘beyond question...much of the aggressive and suicidal behaviour of the mentally ill is largely an artificial by-product of the way of life imposed upon them’ (Ibid.).

Policy recommendations naturally followed from these criticisms of the hospital-based system.

The time has come when we should ask ourselves seriously whether the interests of the mentally ill are best served by providing more psychiatric beds, building better hospitals. Perhaps we should concentrate our efforts on treating patients in the community of which they form a part and teach the community to tolerate them.

cicals firm Rhone Polenc. It is not to be supposed that this lag of twenty years or so between the availability of the chemical...and it’s effects on hospital practice was due to a lack of merchandising on the part of the merchandisers of Largactil in France.
After all, to remove a person from his locality in which he or she lives will remove support from friends and family, and break links with any social network the person may have, so that, upon return to the community, the person will be isolated and lack social support. In addition, after hospitalisation, the mentally ill, will have the problem of being stigmatised as 'mental patient' Whereas, if services were available on a more normal basis in the community, both these problems could be avoided.

However, there has been a long tradition of 'discovering' asylums and beyond. Scull describes how contrary to the prevailing wisdom that an asylum was a therapeutic institution, there were nineteenth century critics who insisted that it was a prison and confinement likely to intensify rather than reduce pathology. These nineteenth century advocates of decarceration and community care used arguments that are remarkably similar to those employed by twentieth century critics of the hospital-based system. This leads one to suspect that recent developments in community care are not connected to any new knowledge about the 'institutional syndrome' but, are a return to the plight of the mentally ill going back as far as the history of an old knowledge in combination with new technology.

A third approach is to relate deinstitutionalisation to socio-economic conditions. In this tradition, Scull (1977), identifies two major factors prompting a move away from segregative 'solutions' to the problems of the mentally disturbed. The first of these was the post-war introduction of welfare payments to groups not previously covered, guaranteeing at least a minimal existence to the insane poor living outside of institutions. Without some guarantee by the state of at least minimal maintenance outside institutions of relief, and without the provision of medicines at public expense, none of the present alternatives would have been possible. With the advent of the welfare state a wide range of programmes were introduced that could provide just that support.

---

3 Both parliament and the public must be educated out of the 'stereotyped prejudice that sees that the lunatic is a lunatic and the asylum the best place for him...,' and be brought to see that 'future progress in the improvement of the insane lies in the direction of lessening the sequestration and increasing the liberty of them.' Bucknill 1880 , cited in Scull 1984:111
The second major factor, Scull argues, was the subsequent development, from the mid-to-the-late 1960’s of an intensifying ‘fiscal crisis’ of the state apparatus. Under conditions of welfare state capitalism, state expenditures tend to outrun state revenues. O’Conner, argues this arises in part from ‘two mutually contradictory functions’ which the state attempts to fulfill, those of ‘accumulation’, and those of ‘legitimation’ (1973, p.6-7). Increases in proportion of public expenditure spent on social welfare may make a pre-emptive claim upon government resources, or by straining capabilities of states to meet them may even trigger a political transformation. It is in this context that decisions on the structure of health system become a matter of international pre-occupation.

Scull’s thesis has been criticised (Sedgewick, 1982), for presenting a relationship between the adoption of the policy of deinstitutionalisation, on the one hand and the advent of welfare capitalism and the growing fiscal crisis of the state apparatus on the other, as being too deterministic. A larger comparative perspective reveals that the West European experience is diverse, suggesting the links between the economy and mental health policy are not as automatic and necessary as Scull suggests.

The theory adopted in this study is a structural one. That is the view is taken the economic system forms society’s foundation on which the political and social institutions are based. And it is changes in the economic system which bring about changes in the other systems. There are problems inherent in approaches which emphasise the relations between the needs of capital accumulation and

---

4 James O’Conner, argues the state has two general functions; ‘accumulation’, and ‘legitimation’ That is, firstly to secure the conditions for the successful accumulation of capital. And secondly, at the same time, to preserve the legitimacy of the system, to maintain the so called ‘social harmony’. The first the reproduction of labour, represent a form of social investment, directly or indirectly increasing the the productivity of a given amount of labour. (e.g. spending that will result in a healthier, educated and better housed workforce). The second, spending on ‘social expenses is not even seen as indirectly productive, but mainly as a mechanism for the maintainance and control of the surplus, economically redundant population. (e.g. spending on the mentally ill, the elderly, and criminal).

5 Claus Offe, suggests more specifically the point may be reached where capital interests rebel against the borrowing and taxing powers of the state, and where consequently the state will rationalise or cut back on expenditure (1984, p.113).

6 Current economic problems are not only caused by an increase in expenditure. They are caused by inflation, and a decline in productivity, a combination called “stagflation” It is beyond the scope of this paper to attempt an account or analysis of the manifestation of this crisis, suffice to say they have also contributed to budgetary pressures.
the actions of the state, and it is argued that a more helpful theory will also take account of the role of ideas and values in determining social policy. It is my hope, that such an approach allows us to build on the other explanations, and understand a number of crucial aspects of the deinstitutionalisation movement, which the other approaches ignore or are unable to explain.
Marxist theory and social policy

The purpose of this first chapter is not to present a systematic analysis of Marxist theory, but as a preliminary to the analysis of deinstitutionalisation that will follow, link theoretical analysis of the state in capitalist society with analysis of social policy. In this way developing a more critical approach than the "humanitarian" explanation of mental health reform and change. It is important to remember however, that there is a gap between theory and reality, the most that can be said for a theory is that it is more or less helpful in understanding a given set of circumstances.

The state is generally defined as "the political organisation constituting the basis of civil society." (New World Dictionary, 2nd edn.) The state as institutionalised power, consists of the executive, the legislature, the judiciary, the administration, the police and armed forces as well as the "sub-central" government (Milliband, 1969, p.49-54). In modern society, the strategic field of the state stretches far beyond this "public kernal", into most areas of life including the apparatus of mental asylums and hospitals.

Neo-Marxists argue the state is "relatively autonomous" from both the economic structures of capitalist social formation, and from the politically dominant classes in these social formations. Thus, Marxist thinking has broken with the classic Marxist analysis of the state, as a mere tool of the dominant classes. Poulantzes writes,
This relative autonomy allows the state to intervene not only in order to arrange compromises vis-a-vis the dominated classes, which, in the long run, are useful for the actual economic interest of the dominant class or factions; but also...to intervene against the long-term economic interests of one or other factions of the dominant class: for such compromises and sacrifices are sometimes necessary for the realisation of their political interests.

(1978, p.133).

In order to organise the status quo, the state depends ultimately on the use of organised force or repression. (e.g. police and armed forces). But equally specific to maintaining social consensus is the state’s role in organising the dominant ideology and sharing of material benefits. Poulantzes writes, “the state is not reducible to ideology plus repression; the so called social consensus has a material substratum.” (Poulantzes, 1978 p.37).

These tasks of organisation are never tied specifically to one institution or apparatus. Coercive institutions (e.g. prisons, asylums, workhouses) will embody the dominant ideology, such as the value of work and promise material benefits such as rehabilitation and cure. Welfare institutions which are there ostensibly to provide material benefits are widely known for their stigmatizing and coercive effects on the unemployed.

Marxists emphasise the structural limits to intervention by the state. The state may intervene to modify the relations of production, and redistribute powers flowing from relations of possession and economic property. (e.g. taxes, tax relief, health and welfare spending). The degree of redistribution varies, but the bottom line is always that such measures must not destroy the "hard core" or essential characteristics of the social and economic system.

We may express this by saying the capitalist state is constituted by a negative general limit to it’s intervention - that is to say, by the specific non-intervention in the "hard core" or essential characteristics of the capitalist relations of production.


The specific relationship of the state and the economy determine other, secondary limitations. In particular the fact that the resources at it’s disposal are limited. The state is essentially dependent for it’s financial resources on it’s tax base. The state may only impose a certain level of tax without threatening the functioning of the capitalist system by draining capital from private circulation.
It is essentially profits on capital which determine the limits of taxation on incomes and beyond a certain point it is impossible to touch these without seriously threatening the reproduction of the capitalist economy (Poulantzes, 1978 p.192).

The growing state intervention in the economy is perhaps best understood in terms of the requirements of the economy. That is, the capitalist system created new needs and new forms of dependencies which could not be met by the family or the local community. That is not to say that social problems such as mental illness, mental handicap and aging are caused by the capitalist system. It is the inability of such groups to live independently, without support from their fellow citizens, which makes their situation challenging to the ethical values of any society. And it was the decay of the traditional social structure associated, with a transition to a capitalist economy, which made old methods of maintaining such groups seem increasingly inadequate.

Rothman (1971), demonstrates the linkages between the campaigns for state asylums for the mentally disturbed and campaigns that created prisons, workhouses, reformatories and orphanages. These 19th century reformers were convinced of the humanity of an “institutional solution” to the problems of madness, crime and unemployment that were rapidly rising. These social reformers were seen as

rescuing the mad from maltreatment, neglect and inhumanity and ushering in a golden age of kindness, scientifically guided treatment and cure.

(Scull in Bean, 1981 p.333). The almshouses and prisons were proving inadequate to cope with the rising numbers of mentally disordered and deviant people; and Poor Laws were not effective in containing poverty. Rothman (1971, p.xviii) says of the early nineteenth century reformers:

The response in the Jacksonian period was first and foremost an attempt to promote the stability of society at a moment when traditional ideas and practices appeared to be out-moded, constricted and ineffective

The asylum could restore the Republic’s balance while at the same time eliminating these social ills.

There was a Utopian flavour to this first venture which looked to reform the deviant and dependent and serve as a model for others. The well ordered asylum would exemplify the proper principles of social organisation and insure the Republic and it’s glory.
Thus the mental hospital was an instrument to promote stability in society as well as to provide more efficient and humane care of the mentally ill.

An analytical distinction must be made between historical origins of policies and of the welfare system as a whole, "from the ongoing function they play within a particular social formation" (Gough, 1975, p.75). Some of the early hospitals were places of intense optimism and therapeutic activity. They were the ones most influenced by the principles of non-restraint and "moral management". Nineteenth century psychiatrists believed a psychological approach could cure mental disease. Samuel Tuke writes of the assumptions upon which the York Retreat in England was based.

Insane persons usually possess a degree of control over their wayward propensities. Their intellectual, active and moral powers are usually perverted rather than obliterated; and it happens not infrequently that only one faculty is affected.

The York retreat served as a model; its theory and practices became diffused through the western world. And nineteenth century reformers campaigned on both sides of the Atlantic to translate the moral treatment mode of care into a state system of support and care for all disturbed persons.

In order to "cure" the mentally afflicted, the moral managers segregated them in isolated institutions. The medical purpose was to "increase reason". Psychiatrists argue that sometimes it cannot be done without decreasing the liberty of the person. Therefore, the other purpose of the mental hospital is to control. All professions do not view conflicts from the same perspective. Mathiesen (1982), states that physicians see conflicts as problems of treatment while sociologists see them as problems of control. Goffman suggests,"that part of the official mandate of the state mental hospital is to protect the community from danger and the nuisances of certain kinds of misconduct." (Goffman, 1961: p.307).

The Marxist view is not just to see the mental hospital as an institution of control but specifically as one of the "sites of power" of the state. Poulantzes writes,

..the state is always rooted in its physical constraint and manipulation of bodies. In every state, this takes place in one of two ways: through institutions which actualize bodily constraint and the threat of permanent mutilation (prison, army, police and so on); and through a bodily order which institutes
and manages bodies by bending and moulding them into shape by inserting them in the various institutions and apparatuses.

The diagnosis of the patient is an indicator of the medical purpose. The legal status - either voluntary or involuntary indicates the purpose of control.

The distinction between coercive and medical functions of the asylum cannot be sustained. While a great deal of treatment is based on medical fact, the remainder rests on criteria for determining normality which have their basis in the behavioural realm. Foucault observes:

The new meanings assigned to poverty, the importance of work, and all the ethical values that are linked to labour ultimately determined the experience of madness and inflected it's course.

(Foucalt, 1971 p.61). The normative content of medicine seems to capture the norms of the Protestant work ethic. That is not to say psychiatry is only ideology, or hospitals only institutions of control, that is to separate them from the history of science. But we can speak of psychiatry as emanating from the dominant ideology.

The third function of the mental hospital is accommodation. The hey day of the asylum is also the era of “indoor relief”. That segregative form of solution witnessed in the construction of prisons, workhouses and orphanages. The nineteenth century Poor Law demanded as a condition of relief incarceration in a “total institution”. Traditionally the hospitals have an important role accommodating “pauper lunatics” For many, lacking any other means of social support the hospital is their home.

To sum up, the mental hospital has three specific purposes; cure, control and accommodation. This division of functions is one that fits a Marxist analysis of social policy in capitalist societies. Gough (1975), describes social policy as; “The use of state power to modify the reproduction of the labour force and to maintain a non-working population.” The first, spending on “social capital” or “social investment”, may be said to have the specific function of reproduction of the labour force; directly or indirectly increasing productivity of a given amount of labour. This relates to the “curing function” of the mental hospital. The second, “social expenses”, is not even indirectly productive but is seen mainly as a mechanism for the maintenance and control of the surplus,
economically redundant population. Spending on the custody and care of the elderly, the chronically mentally ill may be categorised as “social expenses.”

In the post-war period mental hospitals were facing a crisis situation. The widespread unionisation of state employees and the associated, “advent of the eight hour day and forty hour week in state institutions ... virtually doubled costs.” (Dingman, 1974 p.48). On top of this there was a “crisis of numbers” as the numbers of patients in hospitals continued to rise each year and every year, causing problems of overcrowding and understaffing. This was compounded by the fact that many of the institutions were old and outdated and there were:

...serious matters requiring attention such as the renewal of engineering services, modernisation of sanitary annexes, improved facilities for the treatment and classification of mental patients and the general upgrading of patients's accommodation, by providing for more privacy and storage, space for clothing etc...

(U.K. Chief Medical Officers Report, 1954). In the United States, President J.F. Kennedy, in a message to the nation (1963) reported that nearly one fifth of the nations state institutions are, “fire and health hazards”, most of them dating from the nineteenth century. And that nearly half of those in state mental institutions are, “in institutions with over 3,000 patients, where individual care and consideration are impossible.” (Kennedy, 1963). To the extent that standards were improved and capital investment was made in maintaining and building a new hospital network, it would have meant incurring tremendous social expenditure.

Two events took place that provided an unusual opportunity to change patterns of care; to shift from in-patient to out-patient care and thus reduce costs. Firstly, psychocative drugs introduced in the 1950's promised a chemical means of cure, suited to out-patient treatment. It thus became possible (at least in theory) to treat in the community many who in the past would have been hospitalised. Secondly, as part of the general trend towards a welfare state, there was inclusion of the the chronically disabled in social assistance programmes. Thus it was possible to maintain the chronically ill outside the hospital.

Based on theory, I would hypothesise that the drugs and the welfare provided the pre-conditions for a move from the hospital to the community, but in themselves they are not sufficient to explain
the reversal of policy. It is in the context of the increasing expense of traditional institutional care, together with the possibility of a cheaper, "less restrictive" alternative that caused groups in society to question the role of the mental hospital. That is, in this specific area of the state there is a convergence of concern for individual liberties and reduced obligation to provide social welfare, and when these converge and are present in the context of technological and economic change, policy shifts will result.
A comparative approach is useful in the development of systemised and coherent theory.

Science begins with the effort to order and classify the objects of the universe. This is first a job of comparison, but comparison is not limited to the purely classificatory. It can and must be used as a method for determining useful theories.

(Apter & Eckstein, cited in Higgins, 1981, p.12). Probably the main advantage of the use of comparisons to explain and evaluate, is that one looks not only at variables that vary but also contexts that vary; thus comparative analysis can differentiate between culturally specific causes and those that are characteristic of certain systems. In Higgins’s words, “Analysis, explanation, and the making of generalisations frequently require the use of comparative data.” (Higgins, 1981 p.12).

Issues.

The essential task of the comparative technique is to seek out similarities in the relationships between variables under different conditions, while other conditions are held constant.

The particular comparative method I will be using is known as the “most similar systems design” (Prezworski and Teune, 1970 p.32)
Smelser, (1973, p.113) identifies the problems which the comparative analyst has to deal with as:

...data which cannot be controlled experimentally and a number of cases which is too small to permit statistical analysis

He states that the proper method is to investigate comparable cases:

The more similar two or more cases are with respect to to the critical variables ... the better able is the investigator to isolate and analyse the effects of other variables which may account for the differences which he or she may wish to explain

It is a criticism of Marxist writers, that while acknowledging the desirability of comparative analysis, they have tended to draw upon a limited range of cases in reaching their conclusions (Higgins, 1981, p.170). I will attempt to make comparisons and contrasts between four countries, which represent a range of advanced capitalist states with liberal democratic polities; Denmark, Finland, the United Kingdom and the United States. These four states are similar in a number of key variables which will be treated as constants, but dissimilar so far as those variables with which I want to relate together. They all have available the technology and welfare to maintain and control the mentally ill outside institutions, and they have all suffered from some degree of fiscal stress. There are differences in class structure and ideology. Some countries have a “protectionist” or collectivist ideology, while others are inclined to laissez-faire and individualism.

According to my hypothesis if protectionist and collectivist values are strong, conservative as well as socialist parties will tend to be in favour of public provision of welfare goods. And there will be resistance to any trend to “cut back” or dismantle hospital services. By the same token, if libertarian or laissez-faire concerns are dominant, there will be an ideological commitment to reducing the size of the public sector. And, in this situation, deinstitutionalisation is more likely.

There are a number of problems with this method. Firstly, the problem of causal over-determination; although the number of differences among most similar countries is limited, it will almost invariably be sufficiently large to “over-determine” the dependent phenomena. That is, there is more than one factor which ranks Denmark, Finland, United States and United Kingdom as different, so there is more than one possible explanation for the variation observed. A second problem, relates to the difficulty of selecting cases. Holt & Turner (1970, p.13), argue comparable
cases are so rare that choice of research sites dictates the hypothesis. A third criticism of the comparative method is that it can only lead to partial generalisations, while the real need is to make generalisations that are of universal scope and validity. Again a valid objection, but partial generalisations may be useful as a first step and may be followed by repetition in different settings. Obviously there are major problems with the use of a comparative method, and a clear awareness of it's limitations is necessary.

In conjunction with the comparative method, I will be using case studies. The advantage of case studies is that by focusing on a single case, that case can be examined even when research resources are fairly limited. The scientific status of the case study method is fairly ambiguous, however, because science is a generalising activity. A single case study can neither constitute the basis for a valid generalisation, nor the ground for disproving as established generalisation. Indirectly, however, they can be useful in the establishment of general propositions and thus theory building.

**Dimensions of Comparison.**

What I have attempted is a cross-national, historical analysis of trends and patterns of services between countries at a similar stage of economic development. First, in order to link mental health policy to the wider health system, I will make a simple classification of each country's health policies by their ideological and normative content, which reflect the concerns of dominant groups in society. Secondly, in the brief case studies I will attempt to identify a shift in public policy making from hospital to community-based mental health services. This involves looking at the way public actions are argued, explained and justified. The underlying assumption here is that what policy makers think and do makes a difference. Much of comparative analysis seems to proceed on the assumption that the official rationale for policy is either suspect or irrelevant. That is, it is largely "rhetoric" or "rationalisation" and the real cause lies deeper. However, to take the language of policy making seriously, is not to abandon theory. Rather, to assume interest underlies argument.
And finally, in a simple table, to compare and contrast the levels of hospital services over the period 1950-1980. This is useful as a manifestation of the policy of deinstitutionalisation.

**Indicators.**

Ideology, and relative commitment to collectivist or libertarian values are materialised in the customs and institutions of a state, such as the health and welfare institutions. They can not be measured per se, but dominant concerns and values are indicated by the structure of services. The continued use of the mental hospital as a mechanism of treatment, and accommodation is more easily quantifiable. Inputs can be measured as personnel, money or beds. Outputs as length of stay and admissions. In the table comparing levels of hospital services (1950-1980), I have used total beds per 10,000 of the population. It is a fairly simple economic indicator, it does not show other factors such as staff per person, or the quality of services. But it is useful to show the process of deinstitutionalisation as measured by a reduction of hospital services since beds are an essential element of such care. In addition, I have re-produced data issued by the individual countries on resident population, admissions, and length of stay, to show the changing role of the mental hospital in an increasingly mixed system, in particular a change from it’s traditional role as a provider of long-term care, to a focus on acute care or treatment.

**Sources**

There are a number of methodological problems with this comparative analysis. First, the lack and ambiguity of comparable data. International statistics on psychiatric services are remarkably difficult to find. The statistics produced by the World Health Organisation are confined to hospital services and then only to an enumeration of hospital beds. As a result, in the case studies I have used statistics produced by the individual countries on length of stay and admissions. As they are
produced separately they are not strictly comparable, nevertheless they are useful to show the general trends.
Findings

This section reviews the trends and changes in mental health policy of the four nations at a similar stage of economic development. Evidence is presented to suggest that indeed there is a trend to deinstitutionalise, but that the timing and extent of the decline of the traditional mental hospital varies. This would suggest the presence of some additional variable. It is argued that mental health policy has an ideological and normative content which reflects the concerns and interests of various power groups in society.

Health system.

Comparison of the national health systems yields two broad approaches to health policy; one that sees health as a commodity to be bought and sold in the market, and another which sees it as a public good to be governed by non-market criteria such as need. These two positions reflect the social values that Donabedian (1971), argues underlie a "libertarian" or "egalitarian" approach to health. In essence, the libertarian approach is one in which access to health care is part of society's reward system and people who wish should be able to purchase better care for themselves. The
egalitarian approach is one in which access to health care is a right as citizens of the welfare state regardless of class or ability to pay. Under the former view defence of choice and the freedom of the individual is translated into a defence of the free market place in the provision of health, with only minimal public provision for the poor. Under the latter view, the public system should predominate with little or no role for the market.

While countries differ markedly in their attitude to private markets in welfare, in all countries there is some mix of public and private care, and no country has a totally "pure" system of either kind. As Higgins observes: "The varieties of mix and, to some extent, the ingredients of the mixture are very diverse" (1981, p.59).

Much of the debate in social policy focuses on the borderline between public and private systems, although the boundary is sometimes difficult to determine precisely. "Privatisation" represents an attempt to shift the balance between public and private services and establish a new equilibrium, it also involves altering the character of services provided. While it may involve the dismantling of certain aspects of public welfare services, it is concerned with re-structuring welfare services, especially the balance between public and private finance.

The position that any country occupies on the range of systems of public and private welfare (insofar as it is possible to categorise welfare) rests primarily on dominant values and attitudes, including attitudes towards the role of the state, individual freedom, and private enterprise (George and Wilding, 1976; Mishra, 1981). These depend to a considerable extent, on the particular balance of the conflict between the dominant and subordinant classes in society. Since this balance may change over time, the importance attached to values may change and so, in turn does the mix of public and private services (Tawney, 1964, p.124). Deinstitutionisation is one manifestation of these social changes and of the increased prominence given to individualistic values - just as the institutionisation of the welfare state after the war reflected a different balance of class relations and the collectivist values it promoted.

Findings
The United Kingdom, Denmark and Finland have health systems that have institutionalised a collectivist or egalitarian approach. They have a system of group responsibility. Individual sickness funds have been replaced by unified schemes and general taxation funding. In these countries most treatments are free to the individual and do not attract a specific re-imbursement. By way of contrast in the United States insurance is for the majority an individual responsibility, with payments by third parties, such as Blue Cross and the Federal Government through Medicare (for the elderly), and Medicaid (for the poor). In Denmark, Finland and the United Kingdom, the state is responsible for the organisation of essential services. The private sector is more or less non-existent in the Nordic countries and plays only a minimal, although growing role in the United Kingdom. Hospitals are owned, operated and paid for by the government and physicians are paid a salary. Whereas, in the United States, most hospitals are owned by independent non-profit organisations and physicians are autonomous contractors.

There is a traditional separation of physical illness and mental illness. It is partly for this reason that when attention is confined to the psychiatric services differences become less acute. For much of the last century-and-a-half psychiatric care meant asylum care. And in each of the four countries, including the United States, psychiatric care has been predominantly a public responsibility. This reflects the nature of the asylum as “social expenses”, a mechanism for the control and maintenance of a group of the non-working population. Even now large numbers of the mentally ill are dependent on social assistance, either for treatment costs or subsistence costs. This boundary between physical and mental care, between social capital and social expenses may also be said to have shaped the kind of services offered; mental health services in each of the countries is a “Cinderella” service, receiving a relatively small share of the health budget.
Mental health policies

The problems facing mental health policy makers were remarkably similar, for all Western industrial nations are:

... inheritors of a common legacy: a network of overlarge and decaying hospitals remote from the populations they serve, their major task having been to accommodate long stay patients, even though late in their life they turned to an acute clientele.

(Mangen, 1985 p.13). Beyond these mental hospitals the boundaries of the health system are less distinct and vary somewhat among the four. In the U.K., there is a comparatively long tradition of local authorities providing out-patient and day care facilities. Whereas, the U.S. has relied predominantly on the mental hospital and office psychiatrist and only developed alternatives later. Each of these countries approached the problem in a different way: some began a policy of dismantling the old hospital sector, ultimately with the aim of developing community-based care; while others invested considerable capital resources in building a new hospital network.

Nevertheless, in more recent times there is a significant degree of convergence among the mental health policies of the four: a policy to close or reduce the size of the traditional mental hospital, with large numbers of the mentally ill being transferred elsewhere; a preference for psychiatric units in general hospitals where the focus is on acute care; the creation of locally-based services; the growing reliance on services in the private sector; and renewal of interest in lay and self-help. I make no claims that this list is exhaustive or properly distinguishes the differences that still exist between the states but, should serve as some introduction to the case studies.

United Kingdom

The 1959 Mental Health Act is generally regarded as the first official document establishing a new direction in social policy. According to the Minister of Health,
One of the main aims that we are seeking to prove is the general reorientation of the mental health services away from institutional care to care in the community.

The 1959 Act did not make any financial provision for this alternative policy, neither did it become a statutory duty for local authorities to provide the services which the Act cites as essential to reduce the in-patient population. The Act was primarily concerned with altering, the law relating to the commitment, detention and release of mental patients.

J. Enoch Powell, Conservative Minister of Health, predicted in a speech to the National Association of Mental Health, that by 1975 the 150,000 psychiatric beds would be cut in half. Ultimately the mental hospital would be redundant, it's place taken by psychiatric units in general hospitals. Powell condemned the legacy of Victorian institutions as out-moded and meriting destruction.

There they (asylums) stand, isolated majestic, impervious, brooded over by the gigantic water tower and chimney combined, rising unmistakably and daunting out of the countryside - the asylums which our forefathers built with such immense solidity.

(Powell in NAMH, 1961, p.6). Powell warned that the phase-out of the asylums would not be easy. Yet he predicted that the asylum was a doomed institution and that he was lighting the mental hospital's "funeral pyre" (ibid.).

Powell's rhetoric was based on a statistical study done by the Ministry of Health and the Registrar General's office, that projected a decline in hospital resident population (Tooth & Brooke, 1961). The projections were based on the declining trend in hospital population between 1954-1959, without any allowance being made for demographic change or the development of alternative services. It would seem Powell's ideological commitment to scaling down the National Health Service, was conveniently reinforced by the Tooth & Brooke projections, Armour describes Powell as the "well known ultra-conservative critic of the English welfare state turned manager of one of it's centrepieces, the NHS" (1981, p.246).

Between 1961 and 1971, mental health policy remained unchanged. The principal planning document of the 1970's is the Labour Government's white paper, "Better Services For The Mentally Ill". In sharp contrast to it's Conservative predecessor, the tone of the 1975 plan was modest and planning horizons were pushed into the next century. The long term aim of the Labour govern-
ment was the establishment of a comprehensive locally based mental health services. soon after "Better Services" came a government. However, the Labour government shaken by the oil crisis, was in no position to allocate the huge expenditure required in the short term for the establishment of new community provisions. Accordingly, it was stressed that reforms would have to be achieved through redistribution of existing resources. (Better Services For The Mentally Ill, 1975).

Since the 1950’s, the numbers resident in mental hospitals has fallen consistently and is currently below half the level of 150,000 in the mid-1950’s. The majority of care is still provided by approximately 100 mental hospitals. Bed capacity has declined (see table 1) although not as sharply as earlier plans predicted. The latest estimate suggests that at the end of 1983, approximately 69,000 beds (16/10,000) were occupied. (DHSS 1984.) The average length of stay is shorter, with less than 4% of current admissions remaining in hospital for more than a year of more. Although statistics between regions vary, first admissions rates declined by some 25% in the 1970’s, although readmissions increased by 10%. By 1980, 160 psychiatric units had been established in general hospitals around the country. These units now account for 10% of the beds and in 1981 they received 40% of admissions as compared with only 15% in 1970. (DHSS, 1984b) There are few office psychiatrists, out-patient care is mainly based at NHS hospitals. In 1981 there were 21 million visits, a 9% increase over the figure for 1976.

In the meantime, the development of day care provisions has been slow and varied between regions. In the late 1970’s less than half the local authorities provided hostels.

**United States**

Since the passing of the Mental Retardation and Community Mental Health Centres Act (1963), federal policy has been to encourage and foster the deinstitutionalisation of mental hospital patients and the development of out-patient care through comprehensive, community mental health centres.
In a message to the nation, President J.F. Kennedy set the goal of halving the institutionalised population and the establishment of community based treatment.

If we launch a broad new mental health programme now, it will be possible to reduce the number of patients under custodial care by 50 per cent or more. Many more of the mentally ill can be helped to remain in their own homes without hardship to themselves or to their families. Those who have been hospitalised may be returned to a useful life.

(1963, p.2).

To implement the concept of community care, Kennedy called for the development of community mental health centres, which would provide a continuum of care. Federal aid would help establish the centres, but the major proportion of their funds would come from state and local sources, and from health insurance and third party payments. Kennedy’s advisors also envisioned that funds would be diverted from the hospitals to community based care as the hospitalised population decreased.

In a congressional testimony, the conservative interpretation of the 1963 CMHIC Act was revealed. HEW’s Jones, said:

So what we are really advocating Mr. Chairman, is, in a sense, removing the care of the mentally ill from complete...responsibility of the state through tax funds and direct operations in these isolated, large state mental hospitals, and putting this care back in the community to be financed and supported and operated through the traditional patterns of medical care to which we have become accustomed in this country. This means providing for the mentally ill in precisely the same pattern that we provide for the physically ill.

(Jones quoted, in Armour, 1982 p.150). The HEW was proposing dismantling the old asylums and in the long term re-privatising the care of the mentally ill.

Care of the mentally ill in the United States has traditionally been a responsibility of state governments. A great incentive to states to reduce their hospital populations was the wish to shift some of the fiscal burden for these patients to federal and local governments - that is, to federal Supplemental Security Income and Medicaid and local law enforcement agencies and emergency health and mental health services. Categorical Aid to the Disabled, became available to the mentally ill in 1963, which made them eligible for the first time for federal support in the community.
Also contributing to deinstitutionalisation was sweeping changes, in the commitment laws of various states. Behind this legislation was a concern for the civil rights of mental patients, much of it from civil rights groups and individuals outside of the mental health professions. The changes made involuntary hospitalisation a much more complex process and made it more difficult to hold patients indefinitely against their will. Thus the initial stage of what had formerly been the career of a long term patient - namely an involuntary indefinite commitment became a thing of the past (Lamb et al, 1981).

During the last two decades, the public mental hospital has experienced a remarkable demise. In 1955 there were 559,000 patients in state mental hospitals, by 1979 this had dwindled to approx. 132,000. This reduction was partly due to shortened length of stay. For example, in 1975 the median length of stay in mental hospital was 25 days, considerably shorter than the median six months in 1955 (Hughes, 1985, p.257). It was also due to a shift in location of care, with an increase in the rate of admission to in-patient units in general hospitals, in Community Mental Health Centres, in Veterans Administration hospitals and to a slight increase in admission to private mental hospitals. Compared with 1955, when no such centres existed, by 1979 such facilities accounted for 14 % of patient episodes (NIMH, 1983).

Finland

By way of contrast to the Anglo-American countries, whose policy had been to encourage and foster the run-down of mental hospitals, priority in Finland went to the construction of a new hospital network. The main reasons for this were the obsolescence of existing hospitals and the insufficiency of beds. (Finland, Social Policy and Health, 1985). The vast hospital construction programme lasted 25 years and included psychiatric hospitals as well as general hospitals. The results of this policy can be seen in the vastly increased hospital sector (see table 1).
A change in mental health policy came in 1972. "One important aim of mental health policy in Finland is to increase out-patient services and decrease the number of mental hospital beds." (A. Hakkarainen, 1986). The political basis for this new philosophy was the Primary Health Care Act of 1972. It was felt that the hospital building programme had not been without its disadvantages. It was very expensive, "expenditure on health, was growing twice as fast as GDP." (Health Services 1971-1980). Despite this, most health indicators, except infant mortality were at a standstill. The hospital centred approach was seen by some groups in society as increasingly unable to meet the challenges of adult morbidity or chronic morbidity (ibid.). A change of philosophy was announced; one that would, "put primary care first". Psychiatric services were included in the primary health care legislation. And a financial reform of 1975 created central government subsidies of new types of ambulatory services: day and night hospitals; home care and hostels.

In Finland there are no separate hospitals for the psychogeriatric patients and the first psychiatric wards in general hospitals were not established until 1980. A study of the Finnish mental hospital population (1966-77), observed

The mental hospital population changed. Only two thirds of the mental patients were real psychiatric cases by the end of the study period. One third of the patients were old people. Almost half of the women were over 64 years of age.

(Anni Hakkarainen, 1985). The study suggests this indicates psychiatric services, that were now provided on an out-patient basis were important in short term care, while non-psychiatric although medical and social purposes were central in the care of long term patients.

Denmark

In 1956, a government report recommended the building of new psychiatric hospitals. The guiding principle of this act was that psychiatry should be integrated with the rest of medicine. It was agreed that all new psychiatric hospitals should be built adjacent to, or as special units in general hospitals, and that they should be much smaller than existing hospitals, some of which had over
1,000 beds. The optimal size for mental hospitals was to be between 300 and 400 beds, giving them a capacity to serve a similar catchment area as an ordinary general hospital and to offer specialist psychiatric services. They were to take care of patients at all stages of treatment, the division between acute and chronic sector being rejected.

The report was published when the Danish economy was improving and conditions were favourable. However, disagreement arose as to whether medium-sized hospitals or specialised units should be built first and eventually the plans were overtaken by the beginning of the recession, so that at the end of the 15 year planning period, only four hospitals had been built (Erik Stromgren, in Mangen 1985, p.67).

During the late 1950's and early 1960's a considerable number of new psychiatric units were established in general hospitals. However, "as admissions to mental hospitals did not decline, it was thought that they must be serving a different population from the mental hospitals." (ibid.) The new units did not reduce the load on mental hospitals which remained in a bad condition. A slight reduction in in-patient population was made possible by a substantial increase of welfare benefits and pensions (1957). Stomgren observes:

One of the consequences was that many of the old and incapacitated persons, who had been unable to manage on their own very small pensions and had been financially better off in institutions, could now be discharged with a reasonable chance of surviving on their own.

(ibid.). Although it is important to note there was nothing like the extent of decline in in-patient population as there was, for example, in the United States.

In 1975 the Minister of Interior Affairs proposed a law de-centralising management of mental hospitals from central government to the counties. The aim was for each of the counties to become self-sufficient in psychiatric services. The counties were each asked to formulate their own plans to the ministry by 1980. One common theme has been the emphasis on outpatient services, with only a few counties planning to extend inpatient services.
The number of psychiatric hospital beds has declined since the state hospitals were transferred to the counties in 1976. There has been a decrease of in-patient numbers, "The decline in bed occupancy being explained by shorter length of stays of those admitted" (Stromgren, 1985, p.66.) In 1982, 40% of admission were to psychiatric units in general hospitals, although the number of beds they contain is 15% of the total, indicating their focus is on acute psychiatric treatment. Almost 80% of beds are still in psychiatric hospitals, although they account for only 53% of admissions, an indicator of their role as providers of long term care. Some of the elderly have been transferred to municipal and county nursing homes, and this has reduced crowding in mental hospitals.

**Comparative Hospital Services**

New trends in services are fairly well illustrated by the statistics. The purpose of this section is to compare and contrast the levels of services in mental hospitals, 1950-1980. Table 1 compares the total levels of hospital beds per 10,000 of the population cross-nationally and historically. There are definitional and computational differences which means this figure is not strictly comparable cross nationally, but this should not affect the overall trends disclosed.

Figure 1 shows the trend in psychiatric hospital beds since the early fifties, roughly the period during which ideas about community care developed currency. Once again it should be emphasised that the statistics are not strictly comparable, the United States for example, has reported the total number of mental hospital beds available and this includes provisions for neurological patients and the mentally retarded. The immediate impression is that there is no overall trend in the period, 1955-1980. As we have already seen from the case studies, the dates for a commencement of a policy of deinstitutionalisation vary from on country to another. If these critical eras of psychiatry fail to coincide with the timing of pharmaceutical innovation and diffusion, it would appear their relationship to crude economic factors is even more difficult to generalise.
In the U.K. and the U.S.A., the decline in mental hospital services began in the 1950’s, “before the fiscal crisis had been discovered by any economic researcher” (Sedgewick, 1981). However, comparative and historical evidence indicates, even in the 1950’s there were powerful fiscal considerations, specifically the desire to reduce the cost of replacing the Victorian institutions, which were approaching obsolescence. Thus, it may be argued that many of the so called components of the crisis are familiar ones. They reflect long standing dilemmas and contradictions in the making of social policy in advanced societies (Higgins, 1981). The pattern of services in the other two countries would not appear to support an economically grounded thesis. In fact Finland has developed hospital services so that by the end of the study period there were nearly twice as many beds per person as there had been in the beginning. While Denmark appears to have neither substantially added or reduced it’s stock of hospital beds.

The relationship between the postwar “crisis” of the mental hospital, and the policy of closing chronic wards and restricting admissions would appear to hold for the U.K. and the U.S., but not for the Nordic countries. On the basis of my analysis, I would suggest that ideology is a third intervening variable which accounts for this difference.

In the Nordic countries, egalitarian and paternalistic values are dominant. In the Nordic states, while there is no specific right to health in the Finnish or Danish constitution, “the spirit of the law and long tradition, have led to the interpretation that health care is a natural right of every citizen.” Secondly, there is greater acceptance of the state as an agent of social control. “The welfare state restricts and guides citizens so that all citizens may enjoy the social well-being of society.”

By way of contrast in the United States and among the Conservative Right in the U.K., there is a strong ideological commitment to libertarian concerns and values. Redistribution sufficient to prevent destitution is acknowledged to be a state obligation, but beyond that the appropriateness of redistribution is likely to be challenged. In the United States, in particular, the private market in the provision of welfare has greater legitimacy. It is perhaps ironic that the more radical critics of the mental hospital should have become allied with the conservative critics of public welfare.
Radical critics in the Anglo-American countries had pointed to the restrictions and harmful effects of the institutional setting. Bachrach (1976), observes the radical liberal reformers were not just concerned with with a change of location, but (were) also the expression of a philosophy ... which strongly emphasised the people's self-determination and their right to control the forces that affect them.

Despite the upsurge of these concerns in the 1950's and 1960's, it may be argued that these activities do not represent a new approach. Instead, they re-articulate and re-confirm values of individualism, privatism and self-reliance.

However, if we restrict our analysis only to the 1970's, the relationship would appear to change with all four countries reporting a decline, although in the case of Finland and Denmark, it is much less marked. I would suggest that this is an indication of an international trend to deinstitutionalise the mentally ill. Although deinstitutionalisation is perhaps a misleading term as reduction in numbers has largely been achieved by the large scale transfer of patients to ostensibly cheaper forms of institutional care.

While there is a general decline in hospital beds, still there is significant variation in the extent of the decline. Finland (38.1/10,000) has a bed ratio that is by far the highest in the sample and is in fact among the highest in Europe. The United Kingdom and Denmark have a similar bed ratio by the end of the period (approx. 20/10,000). The United States is at the bottom of the league (8.9/10,000). However, on their own these figures are rather misleading. Finland has a policy to reduce it's in-patient sector to 20 beds per 10,000 of the population by the year 2000. (National Board of Health, 1979). And in the United States, the decline of beds in mental hospitals has been accompanied by an equally dramatic upsurge in the number of psychiatrically impaired residents of nursing homes. NIMH data show that by the mid-1970's, nursing homes had become the "largest single place of psychiatric care for the mentally ill" (NIMH Statistical Note No.107, p.2).

The question must be asked why in the last decade, has deinstitutionalisation emerged as a public health issue in the Nordic countries. This new interest would not appear to be connected with any sudden upsurge of new scientific knowledge about mental illness or treatment. On the contrary,
these countries have had use of the new chemical substances for some time. The emerging interest in community psychiatry has therefore to be viewed in the light of changes in society. It would seem from the case studies and the timing of a change in policy that it was the economic crisis experienced by all Western industrial nations since 1973, that forced the Nordic countries to seriously reconsider economic and social priorities. The fiscal crisis provoked groups to question the cost of social welfare and the "aura" which had previously held social welfare above the level of ordinary partisanship. (Walker, 1984, p.56). So that by the 1970's, both governments were challenged to make savings, particularly from the non-productive sector. In Denmark, in 1973 the Progressive Party emerged as a major political force campaigning on a manifesto of tax cuts in the public sector. In Finland the Conservative party has become the second largest party, although still excluded from the Centre-Left coalition.

To sum up, deinstitutionalisation is made possible through technological and economic advances, but it is based on the ascendancy of particular values and concerns, in the long term structural conflict between the classes. In particular, views of the role of the state, individual freedom and the role of the market in the provision of welfare. In the Anglo-American countries change came as a result of a convergence of concerns and interests of radical-liberal and conservative groups in the 1950's. In the Nordic countries it was not until the fiscal crisis of the early 1970's, that conservative and middle class interests became dominant and challenged the scale of welfare and health spending.

---

7 In the past twenty years, public expenditure on education, health, pensions and other income maintenance programmes in OECD countries had grown almost twice as fast as GDP and dominated public expenditure. (OECD, 1985).
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>---</td>
<td>10,108</td>
<td>10,648</td>
<td>10,743</td>
<td>10,778</td>
<td>11,588</td>
<td>9,547</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td></td>
<td>8,946</td>
<td>10,33</td>
<td>16,016</td>
<td>19,104</td>
<td>19,808</td>
<td>19,748</td>
<td>19,564</td>
</tr>
<tr>
<td>Country</td>
<td>beds per 10,000 (population)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>---</td>
<td>23.6</td>
<td>23.4</td>
<td>22.7</td>
<td>21.9</td>
<td>22.9</td>
<td>18.6</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td></td>
<td>22.1</td>
<td>25.6</td>
<td>36.2</td>
<td>41.7</td>
<td>42.1</td>
<td>41.9</td>
<td>38.1</td>
</tr>
<tr>
<td>U.K.</td>
<td></td>
<td>35.5</td>
<td>35.7</td>
<td>32.6</td>
<td>---</td>
<td>26.16</td>
<td>19.9</td>
<td>17.9</td>
</tr>
<tr>
<td>U.S.A.</td>
<td></td>
<td>48.3</td>
<td>48.2</td>
<td>43.4</td>
<td>26.8</td>
<td>21.9</td>
<td>15.8</td>
<td>8.9</td>
</tr>
</tbody>
</table>

Figure 1. Mental Hospital Services 1950-1980

Sources
2. 1980 figure for England is not reported in the WHO publication. The cited figure is from the 1979 Mental Health Enquiry For England. (London, DHSS, HMSO, 1984)
3. 1975 and 1980 figures for the United States are from “Mental Health in the United States”, NIMH: 1983
Problems Faced In The Transition To Community Care

Despite the dramatic decline in hospital services, the development of alternatives has been slow and in some cases, non-existent. In fact, there has been an increasing privatisation of mental health services; reducing the size of the public sector and increasing the role for private markets. As this process continues to gather momentum, there is a need to examine the claims made for deinstitutionalisation and some of the distributive and allocative consequences of this policy.

A striking convergence in the mental health policies of the U.K. and the U.S. is the timing of the demise of the mental asylum. Dating from 1954 in the U.K., and 1955 in the U.S., the numbers of patients resident in mental hospitals has declined each year. In addition, there has been a marked reduction in length of stay. Measured in this crude way, the success of deinstitutionalisation in the two societies is easily shown, although the speed and extent of decline has been more dramatic in the U.S. than in the U.K..

The major difference lies in the treatment of the elderly mentally ill. In the U.S. those over 65 make up a large proportion of those discharged from mental hospitals. Between 1969 and 1974 alone,
the number of patients over 65 in state and county mental hospitals fell by 56% from 135,225 to 59,685. Whereas, in the U.K., those over 65 make up nearly half the resident population in 1977.

The closure of the asylums is only the first stage of the deinstitutionalisation process, the second is the movement to alternative care settings. In the United States, of the proposed 2,000 community mental health centres, only 691 were built by 1980, comprising 27% of in-patient services. Meanwhile in the U.K., the development of psychiatric units in general hospitals has been slow and unevenly spread. Even more patchy are the local authority services which are supposed to provide residential, day-care and out-patient services. Peter Sedgwick observes, "the reduction in register of patients ... has been achieved through the creation of the rhetoric of 'community care facilities' whose influence over policy in hospital admissions and discharge has been remarkable seeing as they do not, in the actual world exist." (Scull in Bean 1983, p.339).

Community care for the mentally ill, the ideology of the community mental health movement, gave a sense of mission to the dismantling of mental hospitals. The idea of community care is based essentially on the idea of local responsibility for the treatment and care of the mentally disturbed. It was argued by not segregating the mentally ill from society, the community approach would help to keep them integrated with their own support network of friends and relatives, and more readily permit a re-establishment of social ties with "normal" society. Instead of the passive and dependent behaviour encouraged by institutional life, community care would restore the independence and initiative of the individual. With psychiatric care provided on the same basis as somatic, the mentally ill would find their needs met with the minimum of disturbance to their lives and in a way that preserves their freedom and social capacities. In Paul Rock's words, most advocates of community care have sought to portray the community as a, "kind of secular Lourdes providing inexpensive redemption".

* Senate Committee On Aging
Meanwhile, what happened to the severely mentally ill as a result of deinstitutionalisation? In the initial years many returned to their families. That is families, and in particular female kin provided the bulk of caring (social division of labour). The Labour government white paper, “Better Services for The Mentally Ill” acknowledges that discharge of patients, where there are no adequate services for them in the community, puts an intolerable burden on families and the community.

The public at large cannot be expected to accept under the name of community care the discharge of chronic patients without adequate preparations being made for aftercare, and who perhaps spend their days wandering the streets or become an intolerable burden in the lives of their relatives ...

Nevertheless, public expenditure constraints have resulted in a drive to increase the role of informal carers and voluntary carers and thus privatise the costs of care.

In 1979 a Conservative government was elected, deeply committed to a policy of public expenditure cuts and an expansion of the economy through private enterprise. The Thatcher government has attempted to legitimise cuts in public services by re-asserting the primary duty of the family to care for its dependent members. According to the Prime Minister:

It all really starts in the family, because not only is the family the most important means through which we show our care for others. It’s the place where each generation learns its responsibility towards the rest of society ... I think the statutory services can only play their part successfully if we don’t expect them to do things that we should be doing for ourselves.

(Alan Walker, 1983, p.157). By presenting the traditional family responsibilities as “natural” or “normal” the state supports and sustains these relationships without appearing intrusive, thus preserving the illusion that the family is a private domain. So the meaning of community care is diluted to mean care by the family, friends, neighbours, anyone but the state.

In this way, untrained and largely unsupported families are expected to cope with the confused and deranged and incontinent, whilst “from the outset those running the centres have displayed a pronounced preference for treating good patients (rather) than schizophrenics, alcoholics or senile psychotics”. For the patients who are in the care of the families, the medical level of care will drop considerably. John Wing has found “the burden on the community and relatives was rarely negligible, and in some cases it was intolerable.” (Wing and Brown, 1970, p.92). But much of the distress and misery remains hidden because of families reluctance to talk about it. As George Brown observes: “relatives are not in a strong position to complain - they are not experts, they may be
ashamed to talk about their problems and they have come to the conclusion that no help will be offered which will substantially reduce their difficulties.” (Brown et al, 1966, p.209).

In the United States, board-and-care homes and nursing homes have become the dominant force in the residential care of the mentally disturbed.9 That the majority of the elderly mentally ill have been simply transferred from one institution to another is suggested by the fact that between 1963 and 1969 the number of nursing home inmates with mental disorders virtually doubled (NIMH Statistical Note No. 107, p.2). NIMH data show that by the mid-1970's, nursing homes have become “the single largest place of care for the mentally ill”, with 750,000 in nursing homes compared to 150,000 still in mental hospitals (NIMH in Newsweek, Jan. 1986). That is, there has been a move from direct state provision of accommodation and medical and social services to public subsidisation and purchase in the private market.10

In addition a large proportion of the mentally ill - in some areas as much as a third between the ages of 18 and 65, live in board-and-care homes (Lamb and Goetzel, 1977). The introduction of “Supplemental Social Insurance” as a federal income maintenance scheme for the disabled, enabled states to discharge patients to be maintained on welfare simply by declaring them competent to live independently. Richard Lamb observes:

> These products of the private sector are not the result of careful planning ... on the contrary they sprang up to fill the vacuum created by the rapid and usually haphazard depopulation of our mental hospitals. Suddenly many thousands of former state hospital patients needed a place to live and, and private entrepreneurs to provide it.

(Lamb, 1986, p.286).

---

9 Estroff 1981: 120; Talbott 1980: 44-45. report that in the 1950’s, 65% of deinstitutionalised patients returned to their families, compared with only 23% now, a figure which drops off sharply within a couple of years of discharge.

10 An important reason for this transfer from one institution to another, would appear to be economic. The GAO estimates it costs the state approx. $1,000 dollars per month per patient in hospital. The cost is is born completely by the State Treasury. The passage of Medicare and Medicaid made it possible to transfer elderly patients to private nursing homes. Since nursing homes are required to employ fewer professional people, overall costs to the state are reduced. The GAO estimate that rather than costing $1000 per month per person, the cost per person is $374 in an intermediate care facility.

Problems Faced In The Transition To Community Care
In the U.K., privatisation of mental health services has not been as extensive. In part this probably reflects the lower numbers of chronic patients discharged. It mirrors also the more entrepreneurial character of American capitalism and the greater legitimacy accorded to the process of the privatisation of state and welfare services (Spitzer and Scull, 1977). In 1981, the Conservative government issued a consultative document “Care in the Community”, in which it was stated that the hospitals had reached the end of their life as viable buildings and maintenance and modernisation could not be justified in this era of fiscal stress (Mangen, 1985 p.245). As many as thirty, about a third of the network, are to be emptied and closed over the next ten years. Alternative services are therefore urgently required. In the context of public expenditure cuts and spending constraints it was unlikely that local authorities would provide residential care for the many thousands of patients who will be discharged as a result of the government’s policies.

In January 1985, the Conservative government set up private accommodation as part of the mental health service. The Local authority has the responsibility to register the homes, and individuals housing the mentally ill will be able to claim about $175 per week per person from the DISS. This form of accommodation, for example with 10-12 residents, and a resident couple acting as care staff is to be the main provider of care in the near future. For the government, this privatises the care of the mentally ill in the community before a nationalised scheme is established.

The conviction that mental patients would receive better and more humanitarian treatment in the community than in the state hospitals remote from home, was a philosophical corner-stone to the community mental health movement. Yet, in many ways the return of patients to the community has led to new systems of segregatation and deprivation. As already noted, many psychiatric patients live in board-and-care homes where they are, “given a shared room, three meals a day, dispensing of medicine, and minimal staff supervision; for a large proportion of long-term psychiatric patients the board-and-care homes has taken over the functions of the state hospitals.” (Lamb, 1986, p.37). The research that has been done on Board-and-Care homes tends to confirm this picture. Lamb and Goetzol (1977, p.29-31), concluded that:
It is only an illusion that patients who are placed in board-and-care homes are in the community. These facilities are for the most part like small, long-term state hospital wards, isolated from the community. One is overcome by the depressing atmosphere, not because of the physical appearance of the boarding house, but because of the passivity, isolation and inactivity of the residents.

Many of them have limited involvement in the outside world and spend most of their time in the boarding house which actually promotes dependency, inactivity and isolation.

Given the general emphasis on the therapeutic value of reintegration into the community, one might have expected that by now, a body of research would have been built up to demonstrate the advantages that result when the functions of the mental hospital are taken over by alternative agencies. In fact, such studies as exist are largely descriptive rather than experimental, and are rarely epidemiological in nature, so that it is difficult to know how far the results can be generalised (Wing, 1978 p.240). For example, a study by Pasamanick (1967) which is often cited as demonstrating the feasibility of maintaining schizophrenics in the community deals only with those who are members of intact families, who only form a fraction of long-term patients. Moreover, a follow-up study with even these patients produced less favourable results (Davis et al., 1974).

On the other side of the equation, there is also a lack of careful and thoughtful analysis of the social and economic costs of maintaining such people in the community - defining cost in the broadest sense, and considering human as well as monetary costs to the patients, their families and the community at large. As Alan Maynard observes:

hospital administrators may define cheapness in terms of a shorter length of stay or the cheapest form of care for a resident group. A shorter length of stay may minimise costs to the hospital but provides no information about the treatment outcome or about the costs of care outside the hospital.

(1986, p.34). In fact, there has been a failure to evaluate all the costs and benefits of community care. State hospital costs are relatively easy to assess, while the true costs of community care are hidden.

In the United Kingdom, the sociologist Richard Titmuss thought it strange that the Ministry of Health should embark on a policy of dismantling asylums. He warned:

To scatter the mentally ill in the community before we have made adequate preparations for them is not a solution; in the long run not even for H.M. Treasury. Considered only in financial terms any savings from fewer hospital inpatients might well be offset several times against more expenditure.
on the police forces, on prisons, and ... more unemployment benefit measured as sickness benefits; 
more expenditure on drugs; more research to find out why the crime is increasing.

(Titmuss, 1961 p.68). Deinstitutionalisation has left large numbers of the mentally ill “at large” in 
the community. At the same time there are limited community psychiatric resources, including 
hospital beds. Society has a limited tolerance of deviant behaviour, and the result is pressure to 
institutionalise people wherever there is room, including prison. A number of studies describe a 
“criminalisation” of mentally disturbed behaviour (Abramson 1972; Lamb and Grant 1982). Thus, 
in a “redeployment of the legal-police network”; rather than hospitalisation and psychiatric treat-
ment, the mentally ill are subject to arrest and imprisonment.

Perhaps the vagrant psychotic, or the homeless mentally ill, above all challenge the present system, 
as by definition they do not belong to the community. Some suggest, “aggressive case 
management” assuming the root cause of vagrancy lies within the individual and that if techniques 
can be found and put into practice to change patterns of living and attitudes, such people cease to 
be vagrant. Whereas, even if these strategies were successful, it would soon become apparent that 
the problem is also lack of resources, and in particular the lack of decent and affordable housing 
(Baxter and Hopper, 1985).

Lamb (1981), and Baxter and Hopper (1982) argue that the survival, let alone the rehabilitation of 
the mentally ill, begins with an appropriately structured environment. They state other treatment 
and rehabilitation are of little use until the person feels secure and is stabilised in her or his living 
conditions. That is, they suggest the controls and structure of the mental asylum may still be nec-
essary for the treatment

Facilities such as board-and-care homes and single-room-occupancy hotels even where they are 
adequate do not attract and keep the mentally ill (Arce et al 1983). If they do enter one of these 
facilities, their stay may be brief. They drift in and out, to and from the streets. Lamb (1984, p.65) 
observer:

Those who move out of board and care homes tend to be young; they may be trying to escape the 
pull of dependency and may not be ready to come to terms with living in sheltered, segregated low
If they still have goals they may find life there extremely depressing. Or they may want more freedom to use alcohol or street drugs ...

Once out on their own, they often stop taking medications, and after a while lose touch with Social Security and may be no longer able to receive their social security checks. There may be no alternative for them but the streets, that is unless they start exhibiting blatantly bizarre or disruptive behaviour that leads them to being taken to hospital again or to jail.

Heidenheimer, et al (1976), have suggested trends to privatise welfare services may be short-lived. Contrary to popular expectations contraction of public programmes will cost money. "Even a policy of non-government intervention", they observe, "requires careful planning and continuous attention by public policy makers." (1976, p.276). They suggest the great weakness of proponents of re-privatisation may be that, like those who would only expand services, those who would only cut back on services disregard the cost associated with the action. However, this does not take account of the strong ideological motive behind deinstitutionalisation, or the fact that the social costs are themselves privatised and atomised. (Alan Walker, 1984 p.42).

It would be wrong to suggest there has been single-minded drive to dismantle the mental hospital network. As Gough observes, some of the tendencies towards re-privatisation of the welfare state have been modified in response to trade union, and other interest group pressure. Thus, despite the efforts of British and American governments to abolish mental hospitals, they continue to exist and account for a disproportionate amount of the mental health budget. In the U.K., hospital services still take up 90% of the mental health budget. In the U.S.A., although 63% of the nation's chronically mentally ill are at large in the community, two-thirds of the state mental health budget goes to mental institutions that now only house a fraction of their former resident population. The result, a staff to patient ratio exceeds 1.5 to 1 in public and state hospitals.

The public provision of mental health care has created a large labour force with a vested interest in the hospital as a source of employment. This is particularly the case as mental hospitals are frequently located in rural areas which depend upon the institutions as an important source of em-
ployrnent (Cramer 1978). Among some of the more qualified staff there is resistance to
dehospitalisation as it clashes with professional opinions and ethics. In particular, psychiatrists
emphasise the problems of trying to treat the severely mentally ill in the community:

caregivers who work with this population daily confront the paradox that extremely needy individuals
reject a variety of services they are offered with good will and make choices that do not appear to
be in their interests.

(Drake & Adler, 1985 p. 141). The recommendation here is for "re-claiming the mentally ill from
the streets" and returning to a traditional model of institutional control and treatment.

The underlying assumption of community care is that the "community" accepts this responsibility.
Apart from the economic issues, there has been tremendous social resistance demonstrated by res-
idents when hostels or homes are proposed for their areas. (Aviram, 1973; Cramer, 1978; Talbott,
1979). The prospects of placing a hostel or treatment facility in their area brings fears of lowered
property values, and results in political pressures for zoning commissions to prevent establishment
of such services. The result has been the development of "psychiatric ghettos" in deprived inner-
city areas.

In the midst of the concerns about the shortcomings and anti-therapeutic aspects of the mental
hospital, it was not appreciated that the mental hospital performed some vital functions for the se-
verely and chronically mentally ill. In addition to food and shelter, these institutions provided
within the hospital a social network, and medical care as well as respite for the patient's family
(Bachrach, 1984). That is not to glorify the role of the asylum for the individual or for society,
simply to point out that even as a coercive apparatus, it had material benefits for the mentally ill.

In the move from the hospital to the community the importance of financial benefits and
medication was appreciated, but the importance of control and supportive living arrangements was
not clearly seen, or at least not expressed. The result is that there is a limit to the extent to which
the functions of the mental hospital have been transferred to the community. Some twenty years
ago, George Brown and colleagues claimed that the test of community service lies in whether it can
meet the needs of the seriously handicapped person who used, in the old days, to become a long-
stay patient. (Brown et al, 1966). Judged in terms of the growing homelessness and criminalisation of the mentally ill, British and American policies would appear to have failed to meet that test.

For different reasons, deinstitutionalisation appeals to a wide variety of political values. It promotes independence, reflects an idealist model of social relations and is thought to be cheaper than institutional care. Examination of the reality underlying this consensus reveals a sharp contrast between political rhetoric and the day-to-day experience of the mentally ill. Far from being care in the community the bulk of caring is provided by families. And when kin are not available, or not willing to take care of their dependent members, they are placed in “mini-institutions” in the community.

The move from the hospital to the community has been assumed to promote greater efficiency, and at best, efficiency and effectiveness have been equated. I have already noted that deinstitutionalisation is not based on effectiveness of services in meeting need, but is based on an idealistic view of the community and a spurious form of cost effectiveness that assumes that reduction in the public burden is a benefit to society. At the best, it can be said deinstitutionisation is the beginning of a re-thinking of alternatives to the mental hospital, at worst, it is one that has severely reduced services for the mentally ill.
Conclusion.

This study confirms much of the original literature while supporting a specific additional hypothesis. That is deinstitutionalisation occurred as a result of a convergence of a number of different factors at a specific time in history - pharmacologic agents, new forms of psychotherapy, income maintenance and powerful fiscal pressures. But it would be a misleading to imply that the change in policy was linear in nature. Comparative data suggest the effect of dominant ideologies in reinforcing or obstructing the move to dismantle the network of asylums.

The conclusion that ideology had a significant impact is useful, albeit limited. Consideration of ideology and class structure represents only one of the many differences that underlie the Anglo-American and Nordic states. No account was taken of other theoretically relevant factors. It should be realised that this is a limited study with a comparatively low level of analytical sophistication and only limited generalisability.

The findings supported much of the literature on privatisation of welfare services. In particular Gough's argument that in an era of structural crisis there will be increasing reliance on the private market and a "re-privatisation" of the welfare state (Gough, 1979 p.138). Although in addition it should be noted that Conservative strategy is not based simply on the interests of private capital and the prescriptions of economic theories, it is also characteristic of a classic laissez-faire aversion...
to the public sector. There are then two threads to the policy of privatising social services.

In the case of mental health services, both of these have been evident, as there has been a re-definition and re-allocation of the services that used to come under the umbrella of the mental hospital, with social and medical care increasingly privatised. The mental hospital remains as a "public floor" to the system.

Despite much simplistic political rhetoric that suggests otherwise, the issue of deinstitutionalisation of the mentally ill is an extremely complex one. In one sense, it is a part of the general debate about the relative merits of market and non-market systems of welfare. In another, it involves issues of control and community in advanced capitalist societies. This study can only be regarded as a preliminary investigation of a complicated subject matter. Given more resources, this study could be upgraded by incorporating a greater number of countries and by a more systematic analysis of the data.

Conclusion.
Bibliography


Arce, A. et al. “A Psychiatric Profile of People Admitted to an Emergency Shelter” Hospital Community Psychiatry 34, 812-817: 1983


Davis, A. Schizophrenics in the New Custodial Community. Columbus, Ohio University Press: 1978

Dingman, P.R. The Case for the State Hospital. Scottsdale, Arizona. NTIS: 1974
Donabedian, A. "Social Responsibility For Personal Health Services: An Examination Of Basic Values". *Inquiry*, vol 8, No. 2: 1971


Feldman, Elliot J. "Comparative Public Policy Field Or Method.". *Comparative Politics* Jan. 1978


Kirk, S. & Thierren M. "Community Mental Health Myths and the Fate of Formerly Hospitalized Patients" *Psychiatry*, 38: 1978
Mangen, Steen P. *Mental Health Care In The European Community.* Croom Helm Ltd, Provident House Burrel Row: 1985


Morgantheau, T. “Abandoned the Chronically Mentally Ill.”, *Newsweek:* Jan. 1986


NIMH, “Abandoned” *Newsweek:* Jan 1986

Pasamanick, B. *Schizophrenics in the Community.* New York, Appleton Century Crofts: 1967


Poulantzes, Nicos. *Classes in Contemporary Capitalism,* N LB: 1975

Powell, E.J. “Opening Remarks”, *Emerging Patterns for the Mental Health Services and the Public.* London, National Association for Mental Health: 1961


Salankangas, K. “Community Psychiatric Services In England and Finland.” *Social Psychiatry* 20: 1985

Scull, Andrew. *Decarceration* Prentice Hall, Inc.: 1977


Slater, Jenny. “Alternatives to the Mental Hospital” unpublished paper, Nottingham University: 1985


Talbott, J.A. “Deinstitutionalization, Avoiding The Disasters of the Past.” *Hospital & Community Psychiatry,* 30: 1978


Titmuss, R. *Community Care; Fact Or Fiction* London, NAMH: 1961


United States. Senate Subcommittee On Long Term Care and the Special Committee on Aging. The Role Of Nursing Homes in Caring For The Discharged Patients Washington DC, Government Printing Office: 1976


Wing, J. & Brown E. "The Re-Location of Released Mental Patients into Residential Communities." Policy Sciences 31-35: 1976


The two page vita has been removed from the scanned document.
The two page vita has been removed from the scanned document.

Page 2 of 2