## Deinstitutionalization Movement Provides Lessons for Reforming Long-Term Care in the United States

Ensuring that the elderly population and persons with major disabilities receive effective long-term services is a major policy focus at the federal and state levels. Half the total cost of nursing home care in the United States is paid for by Medicaid. In 2002 Medicaid beneficiaries who used long-term care accounted for half of all Medicaid spending, even though they constituted only 7% of the Medicaid population.

Policy makers are focused on changing the locus of care from nursing homes to the home and community. This contemporary process is similar in many ways to the deinstitutionalization movement to close large psychiatric hospitals and introduce community-based services in the latter half of the 20th century. A new report from the Kaiser Commission on Medicaid and the Uninsured finds lessons in the deinstitutionalization movement for today's policy makers who are seeking to reform long-term care.

Although the federal deinstitutionalization movement was launched in 1965—through the community mental health centers (CMHC) program—it was not until 1993 that the number of state-controlled mental health dollars allocated to community care exceeded the number allocated to state hospitals, the report notes. In addition, federal funds for the CMHC program did not come close to the amounts promised. Progress was slow not only in shifting funds but also in adopting promising models of community care. Such models were rarely fully evaluated and even more rarely incorporated into practice—with the result that old approaches continued to eat up resources long after more effective models were available. In addition, even after it became clear to policy makers that people with severe mental illness need an array of supports in addition to treatment in order to live in the community, multiple funding streams remained uncoordinated and it was difficult to put together a comprehensive service package.

The report's author, Chris Koyanagi of the Bazelon Center for Mental Health Law, notes, "Shakespeare tells us there is a tide in the affairs of men which, taken at the flood, leads on to fortune. Unfortunately, deinstitutionalization missed the flood. By the time the necessary knowledge existed, political will had faded. The optimism of the 1960s regarding government's ability to solve major social woes was gone. The memory of the snake-pit institutions had faded. The policy picture had become more complex than expected." The result was "a grievous muddle of cause and effect and abandonment of responsibility on all sides."

In hindsight deinstitutionalization as a policy goal can clearly be seen as correct both morally and economically, Ms. Koyanagi notes. But what could have been done differently, and how can lessons learned inform efforts to reform long-term care? First come issues of careful planning and adoption of best practices. Closure of institutions as a matter of principle—closure for its own sake—can quickly gain momentum. Retaining institutional beds while expanding community care may be necessary to ensure that services will be waiting for individuals when their long-term care institutions are downsized or closed. In addition, new approaches to meeting the needs of these populations must be evaluated promptly and systematically, and old approaches must not be allowed to continue beyond their usefulness.

Comprehensive and adequate funding over a sustained period of time is also essential for reform of long-term care. Even though the deinstitutionalization movement has made contemporary policy makers more cognizant of the array of supports needed for people to live in the community—and of their right to choose and self-direct—failure to ensure enough funding may lead to erosion in quality-of-life services, particularly psychosocial services and recreation. Resources need to be managed in a concerted manner across federal, state, and local governments. When large psychiatric hospitals were closed, not enough of the savings followed deinstitutionalized people into the community. Capturing the long-term services resources now spent on institutional care by all levels of government might provide sufficient resources for the alternative services envisioned. The report also warns policy makers to be careful of unanticipated consequences—"perverse fiscal incentives"—when implementing any new financing strategy. For example, early mental health planners did not anticipate transinstitutionalization into nursing homes or the expansion of general hospital psychiatric beds.

Another error that policy makers might avoid by studying the deinstitutionalization movement is replacing one form of long-term care institution (nursing homes) with another (group homes). Similarly, the assumption of early mental health planners that families could take up the slack and provide needed supports to their ill relatives with little help was "a major mistake," the report notes.

The 22-page report, *Learning From History: Deinstitutionalization of People with Mental Illness As Precursor to Long-Term Care Reform,* which also discusses lessons learned in regard to workforce issues and advocacy, is available on the Kaiser Commission Web site at www.kff.org/about/ kcmu.cfm.

## Partnership for Workplace Mental Health Creates Tools to Facilitate Return to Work

Each year approximately 36 million days of work are lost because of declines in productivity related to mental illness. It is therefore critically important that the U.S. employer-supported health care system promote accurate diagnosis and effective treatment with a focus on return to work and that employers adopt policies that facilitate early return to work. To that end, the Partnership for Workplace Mental Health has developed a set of recommendations and tools for use by physicians and employers. The Partnership is a program of the American Psychi-

atric Foundation, with nearly 30 of the nation's top businesses, including Coca-Cola, 3M, Caterpillar, Dow Chemical, and Merrill Lynch.

The recommendations and tools are presented in a 42-page report, *Assessing and Treating Psychiatric Occupational Disability: New Behavioral Health Functional Assessment Tools Facilitate Return to Work.* The report includes four recommendations for physicians and patients. First, physicians should consider it a psychiatric crisis when a person leaves work because of a mental health condition. Second, the employee must secure an accurate diagnosis, with an emphasis on assessment of functional impairment as the basis for treatment and return-to-work plans. Third, treatment plans should address preservation or improvement of function and return to work. Fourth, psychiatric conditions should be considered in all cases of disability, not just those labeled as resulting from a psychiatric cause.

Specific recommendations for employers are also presented, which include establishing policies and procedures to ensure that employees can readily obtain an objective assessment and accurate diagnosis. In addition, employers should intervene early in an employee's absence from work and maintain regular, caring contact with the individual. A team-based approach should be used for return to work by individuals. The teams can be formal or informal and should include the employee and treating physician, employer, the employee assistance program, and health and disability plan representatives.

The report provides five basic assessment tools to assist clinicians in making reliable and consistent work function status assessments as the basis for treatment and return-to-work plans. Among these are two Job Function Forms, one completed by the employer and one completed by the clinician with the employee, that are designed to provide a picture of the mental and cognitive demands of a particular job. The Work Function Assessment Form helps the clinician correlate the job tasks that the patient has not been able to do (disability) with the mental functions (impairment) that the clinician has determined are the medical basis for each functional disability.

In addition to the assessment tools, the report also presents the results of a survey of employers conducted by the Partnership for Workplace Mental Health to document current practices in regard to helping employees with psychiatric disabilities return to work. The report is available at workplacementalhealth.org/disabilityreturntowork.aspx.

## Annual Survey Finds Decrease in Teen Drug Use and Rise in Prescription Drug Abuse by Young Adults

In 2006 an estimated 8.3% of the U.S. population age 12 or older were current users of illicit drugs, according to data from the 2006 National Survey on Drug Use and Health (NSDUH). In the past five years illicit drug use declined 16% among adolescents (ages 12 to 17). In 2006 the proportion of adolescents who acknowledged past-month drug use was 9.8%, which is a significant drop from the 2002 rate of 11.6%. Specifically, current marijuana use by adolescents has declined significantly over the past five years, from 8.2% in 2002 to 6.7% in 2006.

Overall rates of illicit drug use are higher among young adults (ages 18 to 25) than in any other age group: 22.2% for those ages 18 to 20 and 18.3% for those ages 21 to 25. The 2006 NSDUH data highlight the growing abuse of prescription drugs among young adults, which increased 19% between 2002 (5.4%) and 2006 (6.4%). The increase was largely attributable to use of pain relievers, but use of tranquilizers also increased significantly between 2002 and 2006.

Slightly more than half of Americans age 12 or older (50.9%) reported being current alcohol drinkers in 2006. More than a fifth of the population (23.0%) reported past-month binge drinking (five or more drinks on the same occasion), and 6.9% reported heavy drinking (binge drinking on at least five days in the past month). The rate of binge drinking in 2006 among young adults was 42.2%, and the rate of heavy drinking was 15.6%. Among adolescents the rate of current alcohol use was 16.6%, and binge and heavy drinking rates in this age group were 10.3% and 2.4%, respectively.

In 2006 an estimated 29.6% of Americans age 12 or older were past-month users of a tobacco product. Between 2002 and 2006, past-month cigarette use decreased from 26.0% to 25.0%. Among adolescents past-month cigarette use declined significantly over the same period, from 13.0% to 10.4%; however, past-month smokeless tobacco use in this age group was higher in 2006 (2.4%) than in 2002 (2.0%).

The 2006 survey estimated that 22.6 million persons (9.2% of the population age 12 and over) may have had either substance abuse or dependence in the past year. About 2.5 million people received substance abuse treatment at specialty facilities in 2006.

NSDUH is an annual survey of approximately 67,500 people and is sponsored by the Substance Abuse and Mental Health Services Administration. It is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, noninstitutionalized population age 12 years and older. The 266-page *Results From the 2006 National Survey on Drug Use and Health: National Findings,* which features more than 100 summary figures and tables, is available at oas.samhsa.gov/nsduhlatest.htm.