hospitals, patients, and politics

Ronald O. Rieder

"... But what kind of crusade is it to condemn sick and fearful people to shift for themselves in an often hostile world; to drag out ... a hungry derelict existence in a broken-down hotel if they are lucky; victimized, if they are not, by greedy operators of so-called halfway houses that are sad travesties on a fine concept? All without knowing the possibilities of new medical approaches to their illness...."

New York Times Editorial, April 8, 1974, p. 34.

In the 1971 special report of the NIMH Center for Studies of Schizophrenia (Mosher and Feinsilver 1971), the administrators of the State of California are praised for their refusal to build new State mental hospitals, and their closing of one of the State's hospitals is described as an important advance. In that report and the later one (Mosher, Gunderson, and Buchsbaum 1973), there was little questioning of whether this policy is appropriately meeting the needs of the patients involved, and I therefore welcome the decision of the editors now (3 years and five more closed California hospitals later) to bring this issue into debate in the Schizophrenia Bulletin.

Certainly, the debate has already begun outside of the professional psychiatric literature. The press (Washington Post 1974 and New York Times 1974a and 1974b) has been particularly sensitive to this issue, and may indeed be responsible for the slowing down of the trend toward large-scale patient discharges and hospital closings that is now occurring in New York and California (Hospital & Community Psychiatry 1974). The question to be considered here is whether the dissatisfaction with current mental health policies now being reported in the press represents an unwarranted resentment against the presence of mental patients in the community, or a justified concern over their well-being.

In this paper, 1 present 1) the current situation in States in which mental hospitals have been closed and patients excluded; 2) the role of various historical developments and causative factors that have led to this situation; and 3) a brief discussion of the usefulness of psychiatric hospitals and long-term hospitalization.

The Current Situation

In the period between 1970 and 1973, a total of 13 State mental hospitals, in eight states, have been closed (Greenblatt 1974). Still others have been partially closed and converted into community mental health centers. The drop in the population of inpatients of State hospitals started long before 1970. In 1960, the resident population was 541,625, whereas in 1970 it was 350,276, a decrease of 35 percent (Pollack and Taube, in press). It should be noted that the decrease in the patient population over these years included many patients who had had a lengthy stay at the hospital (see table 1).

It is also important to know something about the people who remained in the hospitals after this decade of increased discharges if an appropriate policy for dealing with these remaining patients is to be formulated. This sort of information is, of course, difficult to generate and to summarize. One approach is to look at the diagnoses of the patients who remained in our State hospitals in 1971. According to Pollack and Taube (in

Table 1. Number of resident patients and length of stay in State mental hospitals in the United States during 1960 and 1970.

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Number of resident patients</th>
<th>Percentage of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>1970</td>
<td></td>
</tr>
<tr>
<td>Less than 1.5 years</td>
<td>115,548</td>
<td>96,333</td>
</tr>
<tr>
<td>1.5-4.9 years</td>
<td>133,038</td>
<td>88,415</td>
</tr>
<tr>
<td>5-9.9 years</td>
<td>96,070</td>
<td>44,563</td>
</tr>
<tr>
<td>10 years or more</td>
<td>196,969</td>
<td>120,965</td>
</tr>
<tr>
<td>Total number of patients</td>
<td>541,625</td>
<td>350,276</td>
</tr>
</tbody>
</table>

press), approximately two-thirds of resident patients have a diagnosis of schizophrenia, brain disease, or other psychoses. Since these illnesses tend to be chronic, the question arises as to what the optimum level of functioning of resident patients is. Are most resident patients essentially "boarders" at the hospital, or do they have considerable psychiatric disability? Although there are no country-wide data on this issue, the findings of an NIMH study of St. Elizabeths Hospital in Washington, D.C., are revealing. In a listing of the recommended referral of the entire patient population in the event the hospital were to close, more than 50 percent of the patients were categorized as requiring placement in another total-care institution, a psychiatric hospital, or a nursing home; another 35 percent were considered as suitable for placement in foster homes, presuming 1,248 such placements could be found.

The above figures are the meager data that are available to help us in understanding this situation and, based on this information, it seems apparent that:

- In the period since the mid-1950's, when the use of phenothiazines spread throughout the mental hospital systems nationwide, a considerable reduction in the resident patient population occurred, presumably reflecting the discharge of those patients who responded well to the medications and other active treatments.

- The great majority of patients remaining in these hospitals, though they may be aided by medication, have a considerable residual psychiatric disability.

What becomes of these patients if they receive an "administrative discharge" from the State hospital to return "to the community"? This is a difficult question to answer—or it would be better to say that there is little in the way of available data collected by State departments of mental hygiene or researchers that can help answer this question. Of the 13 papers presented at a recent NIMH-sponsored conference, "On the Closing of State Mental Hospitals," only one reported a followup study of patients discharged to the community. That study (Marlowe 1974), of geriatric patients discharged from Modesto State Hospital in California (an unrepresentative sample of all State hospital patients), indicated what might be expected from the discharge of this subgroup:

Relocation was dangerous for a majority of my patients: deaths were increased, there was a high rate of deterioration, many patients were sent to environments which lacked the basic necessities for a decent life . . . . [p. 120]

Similarly, in a 5-year followup study of long-term patients who had been discharged from Agnews State Hospital in California, Lamb and Goerzel (1972) found that visits to 51 boarding homes and convalescent hospitals tended to support their earlier (Lamb and Goerzel 1971) observations that "most boarding homes are like small wards in the community," and that such homes may represent more of a "retreat from the world" than the State hospital.

Also relevant is a description in an NIMH research report (Wolpert, Dear, and Crawford 1974) on community facilities and what community life has become for many patients discharged from California State hospitals:

With the imminent closing down of California's state hospitals the careful preparation and placement of discharged patients into community board and care homes was accelerated into a steam-roller effect . . . . The steamroller seized upon a conspicuous and an expedient solution which has resulted in the creation of a ghetto of discharged patients, an asylum without walls.

In one area of San Jose, in a neighborhood of about 20,000 residents, adjoining San Jose State University, there are approximately 2,000 discharged patients who are indolent and living in board and care facilities. In some of the larger board and care homes there are often three or four ex-patients to a room and 25 or so in the house, although most of the homes are smaller. The monthly welfare check which may amount to as much as $230.00 a month for the totally disabled is managed by the home operator, who in return provides board and also a weekly allowance of spending money. While there is little or no evidence to suggest that the residents are mistreated or exploited by the operators, there is ample evidence of inadequate community facilities for their further rehabilitation, recreation or other support systems. At least half of the residents are not employable and their daily routine largely involves confinement to their home watching television and drinking beer . . . . [pp. 19-20]

To know more about what has happened to these discharged patients, we must review the reports of others—not researchers, but those who have had closer contact with these patients as they live outside the hospital. Two psychiatrists (Reich and Siegel 1974) who work for the New York City Department of Social Services have necessarily become concerned about the lives of these people, since the welfare system has become the patients' only institutional support:
Less noticed and less publicized, an even more oppressive and appalling state of affairs is unfolding as rooming houses, foster homes, nursing homes, and run-down hotels take the place of former back wards. Here the discharged patients are frequently clustered—unsupervised, unmedicated, uncared for, frequently the prey of unscrupulous and criminal elements. The mass transfer of patients from state care . . . has been without benefit and often with detriment to the patients themselves. The state hospital back ward may be no worse, and is in some respects better, than a coffin-like room at a deteriorated inner-city hotel or Bowery flop house. [pp. 48-49]

Journalists also are aware of and interested in this issue. A series of articles have been published in the New York Times (1974a), mostly on the conditions in New York State:

During the last fiscal year alone, 35,960 mental patients were turned out of the huge institutions, of whom 14,580 went to New York City. But only rarely did they wind up in carefully planned half-way houses. Usually they found themselves in nursing homes for the aged, sleazy hotels, and private houses taken over by operators for quick profit.

Rehabilitation was almost nonexistent for them. They wandered the streets and became neighborhood nuisances as well as objects of fear, for some of them behaved abnormally, panhandled and frightened children in schoolyards. More than half of the patients wound up back in the institutions . . . . [p. 5]

The implication that runs throughout these studies and reports is that many patients, perhaps even most, are no better off outside the hospital. For them, the "alternative care" to the State hospital has been no care at all.

**Historical Developments**

How did we arrive at the situation described above? What prompted the movement to close down the State mental hospital system? Certainly many factors have been involved, but some have been much more important than others, and I believe there has been a lack of recognition of the forces that have been at play here.

Writing of historical forces affecting the closing of mental hospitals, Greenblatt (1974) described the closing as if it were a natural step following upon the development of effective somatic treatments, the concept of the therapeutic community, and the Community Mental Health Centers (CMHC's). This sounds logical—an alternate treatment system develops, employing new techniques, and the old one naturally atrophies from disuse. Unfortunately, it appears from the descriptions above that the patients who have been discharged from or refused admission to State hospitals are not being actively cared for by the CMHC's. In a recently completed evaluation (Scully and Windle 1974) of the extent to which the CMHC program has been achieving its well-publicized goal of reducing State mental hospital utilization, it was found that:

. . . there is no large consistent relationship between the opening of centers and changes in state hospital resident rates. This finding suggests a failure by individual centers to contribute to one of the major stated goals of the Centers Program . . . . [pp. i-ii]

In essence, it appears that the provision of outpatient services by the CMHC's has not significantly reduced the need for State hospitalization. This bit of information is not really news; it is widely recognized that the CMHC's, often predominantly staffed with psychologists, social workers, and psychodynamically trained psychiatrists, would rather treat "good patients" than chronic schizophrenia, alcoholics, or senile psychotics.1

Greenblatt (1974) also mentioned some of the legislative and judicial decisions that are thought to have influenced the process of closing down the State mental hospitals by their curtailment of the commitment powers of psychiatrists. The administrators of State departments of mental hygiene now contend: "We can't commit these patients, we can't hold them, the courts have tied our hands," etc. I think, however, that it would do a great disservice to the lawyers who have promulgated the new commitment procedures to blame them for the present conditions. The altered laws do not and cannot explain why patients who wish to enter the hospitals, wish to remain in the hospitals, or wish to get adequate alternative care are not able to obtain these things. And it must also be recognized that the new laws leave the States the right to argue the case for commitment and necessary treatment before the courts, but this is rarely done. In California, thousands of

1 Further evidence of this preference may be found in utilization figures collected by NIMH. In 1971, for State and county hospitals, schizophrenia comprised 38 percent of inpatient "patient care episodes," alcohol disorders, 17 percent, and organic brain syndromes, 14 percent. The comparable figures for CMHC outpatient services are 10, 6, and 2 percent, respectively. The CMHC's treated a much higher percentage of depressive disorders and "undiagnosed" cases (Taube 1973, p. 41).
patients were certified for hospital stays of over 1 month before the new laws were enacted, whereas only 18 were so certified in 1972 (Urmer 1972). It appears that these new laws can and have been used as an excuse for a policy of not treating psychotic patients, thereby reducing the census of the State mental hospitals.

Besides the factors mentioned above, Greenblatt (1974) mentioned other community forces and judicial decisions which he sees as playing a role in this process:

Contributing to the forces affecting patients' status in hospitals are recent court rulings at federal and state level—pertaining to the right to adequate and appropriate treatment, first pronounced by Judge Bazelon in Rouse vs. Cameron, then greatly elaborated in decisions defining the standards for adequate and appropriate treatment. The most famous of these is, of course, the ruling by Judge Johnson of the Federal Court in Alabama, whose prescription of standards for adequate and appropriate treatment, if supported by the Supreme bench, would perpetrate a veritable revolution in institutional care.

Much of this legal advance, it should be mentioned, comes from the discovery by citizens of the class action vehicle of redress, which potentially gives the citizen advocate great power and can force upon the states huge expenditures . . . [p. 8]

"Huge expenditures" here means spending the amount of money needed to adequately treat psychiatric patients. This is, I believe, the crux of the matter—the budgetary concerns of the State governments faced with the financial requirements of maintaining and improving the State mental hospital system. Even Mosher and Feinsilver (1971), in their special report on schizophrenia, recognized that this factor has been operant, especially in California, since the beginning of the movement to curtail and abolish the hospitals:

In the early 1950's, California's mental health planners concluded that continuously increasing provision of state hospital beds could lead only to ever-spiraling financial and staffing difficulties in the future . . . . It was therefore decided to abandon the effort to build more and more hospitals and provide more and more beds . . . [p. 2]

This penurious logic has continued under the Reagan administration.

Some may wonder how it is that the State government saves money by closing down the State hospitals and developing "alternate means" of care. First, many alternate facilities—convalescent hospitals and boarding homes—have even less professional staffing than the State hospitals. Second, by expelling patients to the community, the State no longer is the sole responsible provider of care. Community funds and federal monies (through welfare and CMHC staffing grants) are also utilized for patient care. Under the old system there was certainly inadequate funding; under the new system there is certainly inadequate funding; but now, under the threat of class-action suits that demand adequate funding and treatment, there is a diffusion of responsibility for the treatment of patients. Conditions in the State hospital were observable, and, I believe, it is in large part because they are observable that the hospitals are being closed. They are being replaced with nothing better (or nothing), except now "no one" can be blamed for the state of these patients and the lack of adequate care. Greenblatt (1974) sums this situation up with what I must regard as unfortunate acceptance:

In a sense, our backs are to the wall; it's phase out before we go bankrupt. [p. 8; emphasis his]

Hospitalization

Along with mental hospitals, hospitalization as a form of treatment has been greatly criticized recently. Mendel (1974) actually stated that it is "never the treatment of choice" (p. 18). His reasoning is as follows:

In terms of the patient's post-treatment function, need for further treatment, improvement in symptoms, and patient career, matched patients who were not hospitalized always did better by all measures than those who were treated in hospitals. [p. 18]

This indictment is strong indeed! What are the data to support such a claim? Mendel refers to four studies: two (Herz et al. 1971 and Wilder, Levin, and Zwerling 1966) compare hospitalization with day hospitalization; one (Langsley, Machotka, and Flomenhoft 1971) compares hospitalization with outpatient treatment; and his own (Mendel 1966) compares short versus long hospitalization. But do these studies, in fact, support the contention that hospitalization is "never the treatment of choice," and support a consequent policy of completely eliminating the hospital system?

Herz et al. and Wilder, Levin, and Zwerling studied day-hospital treatment of severely ill patients. At the 2-year followup, Herz et al. found a decrease in readmission rates, but differences on only 2 of 20 measures of functioning. The Wilder group found essentially no difference in that "day hospitalization is
generally as effective as the traditional inpatient treatment program" (p. 1100). Is this what is meant by the statement that nonhospitalized patients “always did better by all measures” (Mendel 1974, p. 18)? The more important consideration is that Herz et al. found 32 percent of the patients initially admitted as inpatients to be “too ill” to be suitable for inclusion in the study as day-hospital patients. Wilder, Levin, and Zwerling echoed the same warning: They stated both that 90 percent of the patients with acute and chronic brain syndromes were rejected by the day hospital and that with schizophrenic men it is of “doubtful value to impose day hospitalization during the most acute phase of the illness” (p. 1101). What is clear in reading these reports is that these authors recognize that day hospitalization has its limitations; it is not an appropriate treatment for all patients and does not provide a rationale for closing the hospitals.

The Langsley, Machotka, and Flomenhoft study (1971) of outpatient “family crisis therapy” (FCT) as an alternative to hospitalization is similar in its result; they wrote that:

... at both six and 18 months FCT patients were doing as well as the hospitalized patients on two measures of social adaptation and were managing crises more efficiently. [p. 127]

Here again, however, one must note that Langsley and his colleagues were working with a certain group of patients—those who lived with a family within an hour’s travel of the medical center, and whose families were presumably willing to participate. Even with these criteria, hospitalization was necessary for 13 percent of the patients over the first 6 months of the study. What would the applicability and success of such family outpatient treatment be for those patients described above who live in the streets of New York?

The next study is Mendel’s (1966) own. He studied the effect of discharging schizophrenic patients who had been hospitalized for differing lengths of time and concluded that:

The readmission rate of schizophrenic patients discharged to the community over a two-year period is 20.5 percent. The rate of readmissions does not vary with the length of hospitalization during the index period.

And

The post-hospital course does vary in regard to ability to function socially, at work and in the family. Function in these areas is statistically significantly related to the number of days of hospitalization. That is, the shorter the hospitalization the higher the level of function in the post-hospital course. [p. 230; emphasis mine]

Based on the study cited above, one can somewhat understand Mendel’s conclusion that hospitalization is bad for patients, that day hospitalization and family treatment are preferable, and that if hospitalization is necessary, the shorter the stay is, the better outcome will be.

Since Mendel’s (1966) study, very brief hospitalization has become the norm for many California CMHC’s, partly because of a lack of bed space. Fortunately there are some data on what happens with such treatment. Evans, Goldstein, and Rodnick (1973) studied 80 acute schizophrenics hospitalized at the Ventura County CMHC in California. The mean length of stay was 9.5 days. The most striking result was that 39 percent of the discharged patients were rehospitalized one or more times in the next 6 months (p. 670), and most of these readmissions occurred in the first 6 weeks after discharge (M. Goldstein, personal communication). This is the revolving door phenomenon, and it is not the 20 percent over 2 years that Mendel indicates above.

What kind of aftercare did these patients receive? Evans, Goldstein, and Rodnick (1973) write:

Because its treatment philosophy called for brief hospitalization followed by outpatient aftercare, the mental health center encouraged patients to take advantage of available counseling and other therapeutic activities at outpatient clinics after discharge .... The data indicated that 43% of the patients never went to an outpatient clinic, an additional 36% went from one to five times, but only 21% went six times or more. [p. 670]

Do these figures demonstrate the value of brief hospitalization? One possible solution is to increase the aggressiveness of aftercare programs: California is considering a law that would make outpatient treatment mandatory for some. Another possibility is that longer hospitalization, and the facilities for it, may be both necessary and beneficial in this regard. There is one good bit of evidence that this is so. Glick, Hargreaves, and Goldfield (1974) are in the process of comparing the treatment of schizophrenics with short-term (21-28 days) versus long-term (90-120 days) hospitalization. In their initial publication they report:

When global outcome is considered, there is a
small but statistically reliable difference favoring the long-term group. These results appear to be related to the type of posthospital treatment that the long-term patients receive. The greater use of outpatient care by the long-term patients may account for the smaller number of readmissions and fewer days spent in the hospital. [p. 368]

In fact, the necessity of limiting hospitalization to an extremely brief period has furthered a trend that many psychiatrists, whether biologically or psychosocially oriented, would deplore—the immediate prescription of high dosages of phenothiazines for all psychotic patients. In .9 days of hospital treatment, there is no time for careful observation of the patient's symptomatology, for careful neurological evaluation, or for the development of some relationship with the patient before drugs are introduced.

In evaluating the role of the hospital, there are other important aspects to consider. Following a brief hospitalization (2-4 weeks), some patients improve greatly, some incompletely, and some not at all. For those who greatly improve and who basically need help with their return to family and vocational roles, brief hospitalization appears to be useful and adequate treatment. But what of those who do not so improve? Does a "treatment philosophy" of brief hospitalization make any sense for them? One might say that "all that the hospital can do has been done"; but this is not so, for there are new treatments being developed for patients whose psychosis or impairment is not responsive to phenothiazines and milieu therapy (the techniques usually employed). To review them all would be the subject of another paper in itself, but some examples should be given because these are the therapeutic possibilities that many of the briefly treated patients are missing.

Rifkin et al. (1971) are evaluating the use of very high dosages of fluphenazine, and they have had encouraging results. Weinstein and Fisher (1971) reported that electroconvulsive therapy in combination with phenothiazines is effective in young process schizophrenics. Finally, there is a series of studies on the beneficial effects of a token economy program on the behavior of withdrawn, regressed, and aggressive patients (Ayllon and Azrin 1968, Lloyd and Abel 1970, and Galbraith 1972).

Over the past decade there has been a tremendous expansion of research on the psychoses, especially biological research. It is a very realistic possibility that the new therapies for schizophrenia and other psychiatric illnesses which emerge from this research may involve, as do those for heart disease or cancer, some medical risk. The safe dosage range of the phenothiazines is exceptionally large; when future medications are developed, the margin of safety may not be so broad and administration may require considerably more supervision. The experience with lithium and the resultant necessity for monitoring lithium levels in the treatment of manic-depressive illness has given us a preview of these developments.

Given the potential of new therapeutic developments, a policy of abolishing the hospital base that may be necessary for the administration of such treatments seems unwise. Granted, the community hospitals and CMHC's, if given adequate financial support, may be able to treat successfully even a majority of psychiatric patients; but do communities have the resources to develop referral centers for patients who remain psychotic and/or severely impaired? The choice appears to be either the development of such a hospital facility on a State/regional level or the discharge of these patients to boarding homes, convalescent hospitals, or the streets, where they are unlikely to seek or receive further treatment.

Summary

The State mental hospital system, and the patients in it, are in danger of being "phased out" without an effective alternative source of care being available. It is a ridiculous abrogation of our responsibility if psychiatrists and other mental health professionals allow the existing poor treatment of mental patients to be replaced with something even worse.

References


Glick, I. D.; Hargreaves, W. A.; and Goldfield, M. D. Short vs. long hospitalization. A prospective controlled study: I. The preliminary results of a one-year follow-up


The Author

Ronald O. Rieder, M.D., is Research Psychiatrist, Laboratory of Psychology, National Institute of Mental Health, Bethesda, Md. 20014.