better but not well: social and ethical issues in the deinstitutionalization of the mentally ill*

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Introduction

The unintended effects following the 19th century development of large public institutions devoted to the care and treatment of the mentally ill have been well described. Historians such as Grob (1973) and Rothman (1971), sociologists such as Goffman (1961), and psychiatric researchers such as Stanton and Schwartz (1954), Brown et al. (1966), and many others have documented the undesirable consequences of the institutional structures and practices of public mental hospitals upon their patients and staff. Similar criticisms have been directed at institutions established for adult correction, juvenile delinquency, child care, and mental retardation. The result of these criticisms was a consensus of informed public opinion that these institutions, however noble their intended purpose, had become inhumane, ineffective, and inefficient. As a consequence, numerous efforts have been made throughout the nation to develop alternatives to incarceration and institutionalization.

Criticisms of mental hospitals first led to efforts at internal reform and later culminated in policies of deinstitutionalization that were embodied in the community mental health movement and Federal legislation initiated under the Kennedy administration in the mid-1960’s. After a decade of experience with deinstitutionalization and community mental health, a review of social and ethical issues associated with deinstitutionalization is appropriate.

The appropriateness, efficacy, and morality of treatment of schizophrenics and other seriously mentally ill persons in community settings rank very high among the many controversial issues generated by public mental health policies. Legislative committees in New York, Massachusetts, Pennsylvania, and California have reviewed their states’ deinstitutionalization policies. Numerous articles in such newspapers as The New York Times, Los Angeles Times, and the Boston Globe attest to the public’s concern that patients, formerly treated in public mental hospitals, are being prematurely discharged into inadequate residential facilities and aftercare treatment programs. The public also seems concerned that such patients may present dangerous potential for committing crimes, especially of a violent nature. Reflecting these apprehensions, considerable controversy now revolves around the wisdom of community mental health policies and the adequacy of resources available for community treatment programs.

Within the mental health profession there are corresponding differences of opinion as to the adequacy of the evidence for the deinstitutionalization policy and for the scientific basis of community mental health programs. Science, the preeminent journal of the scientific community, has published articles (Arnhoff 1975 and Crane 1974) critical of the scientific basis of this approach to mental health treatment. Arnhoff raised the issue of the community and social cost of large numbers of residential disabled and chronic mental patients to the family, neighborhood, and community. Other clinicians have expressed concern about the burdens imposed on mental patients who are placed in urban environments where there are many predators or discharged into a community where treatment resources may be inadequate.

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In this paper, I will review certain salient developments in the recent history of the mental health programs in the United States and Western Europe that led to the policy of deinstitutionalization as well as discuss some of the social and ethical consequences of this policy.

Remarks in this paper are derived from three sources: (1) My review of the literature, particularly writings on medication, rehabilitation programs, psychosocial treatment, and followup studies. (2) My participation in a number of research projects, including such NIMH Psychopharmacology Research Branch (PRB) Service research projects as the “Acute Phenothiazine Study” with Cole and Goldberg; current involvement in the NIMH-PRB Collaborative Study of Fluphenazine; studies with Ridell in the PURE Project in New Haven on Utilization Review, which involved a study of the adequacy of treatment of schizophrenics in a followup study published by Astrachan, Meyers, and Schwartz; and studies at the Erich Lindemann Mental Health Center on patterns of utilization and followup of schizophrenic patients done by Barrett in concert with Pollack at the NIMH Division of Biometry and Epidemiology. (3) My experience as director of two community mental health programs, the Connecticut Mental Health Center (1965-68) and the Erich Lindemann Mental Health Center (1970-76) in Boston.

In the 1950’s two professional developments occurred that revolutionized the treatment of schizophrenia and other mental illnesses. The introduction of rauwolfia and the phenothiazines, the first of the so-called tranquilizers, has been well documented (Swazey 1974). These new drugs contributed to the effective treatment and symptomatic management of many severely psychotic patients. They also contributed to a reduction in the duration of hospital stays and increased the percentage of patients discharged from hospitals after chronic and acute episodes. These factors made deinstitutionalization possible.

At the same time, new psychosocial methods of treatment in the mental hospital and revised attitudes toward the milieu treatment of schizophrenia appeared in Britain and were later brought to the United States. Included among the new approaches were avoidance of seclusion and restraint, development of large group techniques such as the therapeutic community, upgrading of the education of nonprofessionals, conscious efforts at early discharge, efforts to break down administrative and other barriers between the hospital and the community, involvement of the family in therapy, and a series of developments known at that time as “social psychiatry” (Jones 1953). These efforts attempted to reform the social organization, communication patterns, and power relations internal to the mental hospital.

The therapeutic effectiveness of tranquilizers is indisputable. However, as Mosher (1972) points out, the influence of drugs on changes in treatment may have been the result of the drugs’ indirect effects on psychosocial attitudes as well as their pharmacological effects on central nervous system function. Many of the major innovations in psychosocial practice were introduced before or concurrently with the advent of the new drugs. Immediately before the drugs’ introduction, the California state mental health system began the “total push” policy of intensive treatment for new admissions. The general revitalization surrounding the new program, along with the new drugs, contributed to the 66 percent drop (over the past 15 years) of chronically hospitalized patients in California compared to the nationwide drop of 30 percent. In other state systems, the tranquilizing drugs were “facilitators” of attitude changes through the renewed optimism spurred by their effects on patients previously considered hopeless. The 1961 report of the Joint Committee on Mental Illness and the subsequent founding of the Community Mental Health Centers was another major stimulus to changes in professional and public attitudes.

From the perspective of historical analysis, it is unfortunate that these two events occurred at the same time. This simultaneity has obscured the relative contribution of drugs and hospital reform to the reduction of patients resident in mental hospitals and to the improved outlook for the mentally ill. It is especially difficult in the United States to separate direct and indirect influences of tranquilizers because of the diversity of treatment approaches available and philosophies espoused, coupled with the sparsity of detailed statistical reports. The European data are more easily interpreted. Studies addressed to the question have been done in England (Shepherd 1969), Norway (Odegaard 1964), Germany (Meyer, Simon, and Stille 1964), and Finland (Achte and Apo 1967). All four investigators concluded independently that reduction of the populations of chronic patients had been initiated by social psychiatric reforms before the introduction of tranquilizing agents. Nevertheless, both developments, combined with concomitant changes in public attitudes in the 1950’s, prepared the way for the deinstitutionalization policy of the 1960’s.
Sufficient experience has been gained with deinstitutionalization and community care programs to assess their consequences—whether positive or negative, anticipated or unanticipated—and to identify a number of social and ethical dilemmas. As a whole, patients in the community are “better but not well,” and their limited capacity to lead independent social lives generates complex issues for public welfare, urban zoning, health care agencies, and legal institutions. In some areas there are signs of backlash and calls for reinstitutionalization, as the wave of reform and progress associated with a period of economic growth in the 1950’s and 1960’s now gives way to the retrenchment and conservatism associated with recent economic depression and budgetary restriction. The time is propitious for careful review of recent trends and anticipation of possible and likely future dilemmas and opportunities.

Psychoactive Drug Treatments: The Impact of a New Biological Technology

Concerns over the proper use of psychoactive substances and drugs, natural or synthetic, are among the oldest and newest of humanity’s preoccupations. At the dawn of civilization in the ancient Middle East, alcoholic ferments were widely used, having been developed at about the same time as the domestication of animals, the invention of agriculture, and the first settlement of towns. The ancient Greek Homeric legends contain descriptions of various substances that today would probably be considered psychoactive drugs. Almost every society has developed various potents, brews, and remedies aimed at changing mood and behavior, whether disturbed or normal.

In Western Europe, scientific interest in psychoactive drugs emerged in the middle of the 19th century, when pharmacology and psychology became differentiated as distinct scientific disciplines. In France, Austria, England, and the United States, the opiates, cocaine, and hashish and other derivatives of cannabis fascinated scientists and intellectuals, who became increasingly aware of drugs used in South America, the Middle East, and the Orient.

Psychopharmacology did not emerge as a distinct scientific field, however, until World War II. The term “psychopharmacology” was first used in scientific articles in the 1940’s and 1950’s after the discovery of LSD by Hofmann in 1943 and the synthesis and clinical introduction of chlorpromazine by French pharmacologists in 1950. In the next few years, the pace of development rapidly accelerated as dozens of new compounds were developed for therapeutic investigational use and as various national and international societies were formed.

Today, the science of psychopharmacology encompasses the study of a wide range of compounds, only some of which are used for therapeutic purposes. Psychopharmacology refers to the scientific field concerned with studies of drugs that affect the mind, behavior, intellectual functions, and mood. Psychoactive drugs are those that influence the psychic functions and behavior. Not all psychoactive drugs are therapeutic; heroin, alcohol, and LSD, for example, are psychoactive drugs that generate considerable public and professional attention but have no demonstrated therapeutic value in the treatment of mental illness. Psychoactive drugs as therapeutic agents include antipsychotic, antidepressant, and antianxiety agents used in treating various psychiatric disorders. The success of these compounds has contributed greatly to the changes in the therapy of mental illness, to the restructuring of the mental health care system, and to the strengthening of a medical approach to mental illness.

These new psychoactive drugs, especially the synthetic compounds, are potent enough to be considered—along with behavior modification, molecular genetics, and neurosurgery—sufficiently dangerous, if misused, to merit fear and concern, as well as respect.

In comparison with other techniques for behavior control, such as neurosurgery or operant conditioning, drugs are ubiquitous. Their use is pervasive in our society; in many respects they are deceptively “palatable.” Because we all become accustomed to taking medicine in childhood, we may not readily appreciate the ethical and social issues involved in the use of drugs for the treatment of psychiatric conditions or modification of psychological states.

My initial approach to these issues will be from the vantage point of what is conventionally called the “medical model.” As a physician and psychiatrist, my major interests are clinical and therapeutic. Although there is widespread criticism of the medical model, both within and without psychiatry and the behavioral sciences, I am convinced that the best starting point for the following analysis is from the traditions of therapeutic practice and biomedical research. However, the necessity to go
beyond the traditions of therapeutic practice and the conventional concepts of the medical model soon will be evident. Use of psychoactive drugs generates controversy and conflict because no consensus as to the modes by which individuals and groups should regulate and control dependent and deviant behavior has been reached. Also, these issues require solutions that are social, ethical, and political in nature, rather than scientific and professional.

The treatment of schizophrenic psychoses—the major disabling mental illness—and related behavioral disorders (paranoid, catatonic, and borderline states) has been dramatically changed since the introduction of chlorpromazine and related neuroleptic drugs. While these drugs do not cure psychoses, they reduce manifest symptoms and behavior and facilitate the patient’s remission and social adjustment. The widespread use of these relatively safe compounds has greatly contributed to a reduction in the number of patients residing in mental hospitals, to the shortened duration of hospitalization, and to the shift in the focus of treatment from hospital care to community-based programs (Lehmann 1975).

New Psychosocial Technologies: Reform and Reconstruction of the Mental Hospital Via the Therapeutic Community

As psychoactive drug treatments for the mentally ill were introduced, serious efforts were also underway to generate and apply new psychosocial technologies. These technologies included group dynamics techniques, use of nonrestraint, open-door policies, creation of new professions, and a number of other procedures and methods that at first reflection may seem insignificant. These approaches had three distinct characteristics: (1) They were psychosocial, not biological or pharmacological; (2) They were directly and intently related to social science and historical research and theory; and (3) Their goals included not only the improvement of individual patient care and treatment but also the openly declared intent to reform and reconstruct the social organization and political dynamics within the mental hospital.

That these efforts did not gain so much public attention as new drugs was an unfortunate aspect of the accidental parallel development of the psychopharmacological and psychosocial approaches. However, psychosocial reform and reconstruction efforts quickly affected the mental health professions and were symbolized in theory and research as “social psychiatry” and in practice as “therapeutic community.”

The best starting point for understanding these psychosocial developments was the period after World War II when journalists such as Albert Deutsch wrote of The Shame of the States (1948) and novels and movies portrayed mental hospitals as “snake pits.” These critiques climaxed in Goffman’s concept of “total institution.” In what subsequently has come to be recognized as a classic description, Goffman (1961) identified several similarities among such institutions as prisons, mental hospitals, monasteries, military garrisons, and tuberculosis sanitoriums—all of which he grouped together as total institutions. In such institutions, two distinct groups, usually labeled staff and inmates, live together in a setting physically isolated and socially demarcated from the larger society. Although the two groups live in close physical proximity, they are separated by rigid social boundaries that approach those of a caste system. The inmates’ or patients’ biological needs are met around the clock by the staff, who may or may not live in the institution or on its grounds; but the staff members’ lives, almost as much as their clients’, are subtly determined by the quality of chronicity and deindividualization that characterizes the total institution.

Goffman’s concept of a total institution was offered as a sociological analysis of a unique type of social organization, but he also was proposing a moral critique of these institutions. He described a number of processes in the transactions between staff and inmates (privilege systems, social barriers, “mortification” of the person) by which the institution subverted its own long-term goals. He concluded with a pessimistic verdict that, whatever the publicly mandated purposes of these institutions and the private intentions of individual staff members (professional and nonprofessional), their effects on the lives of the patients were loss of individuality, dehumanization, and depersonalization.

The “total institution” nature of mental hospitals represents a case of unintended consequences. Just as the pharmacologist has learned to regard drugs as having side effects and complications in addition to their intended therapeutic benefits, planners and administrators have come to realize that reforms and innovations carry with them unintended social consequences, effects often contrary to the stated purpose of the institutional goals. The original intent of mental hospitals was to provide an asylum—a protective setting for the mentally ill that...
also would offer treatment and humane incarceration. In the case of modern prisons, incarceration, while providing physical restriction and punishment, also was justified as a preliminary step toward rehabilitation. Goffman (1961), Rothman (1971), Rosenkranz (1972), and other social historians have demonstrated that, whatever the intent of the humanitarian reformers who founded these institutions in the 19th century, the actual consequence, until very recent years, has been the creation of human warehouses that produce humiliation, degradation, and rebellion, rather than treatment and rehabilitation.

The Liberal Reform: The Total Institution Becomes a Therapeutic Community

Goffman's writings synthesized a large body of research on the social and psychological characteristics of mental hospitals that emerged after World War II. A number of studies described the custodial, authoritarian, and bureaucratic nature of mental hospitals that operated to undermine—if not completely to negate—the publicly mandated therapeutic goal and the conscious intent of their leadership and staff. Stimulated by these investigations and by public concern, major efforts at therapeutic reform were widely initiated in the mental hospital field during the 1950's and 1960's. The British "open hospital" experience had begun earlier, in 1946-47. Within mental hospitals in the United States and Great Britain, progressive superintendents and their staffs opened doors and eliminated restraints. They also took steps to decrease the social distance between patients and staff, to facilitate communication among staff groups, and to upgrade employee morale and training. These reforms soon led to experimentation with various alternatives to hospitalization, such as halfway houses and crisis intervention centers, the forerunners of many of today's community mental health and corrections innovations.

These reforms were crystallized in the ideal of the therapeutic community enunciated by Maxwell Jones (1953). Jones united the spirit of egalitarian democracy with the techniques of group dynamics to level unequal status, to facilitate communication, and to share decisionmaking throughout the total institution. His term, the "therapeutic community," became the rallying slogan of the mental hospital reform efforts of the 1950's. Initially developed in Great Britain for the treatment of individuals with personality disorders, the therapeutic community was rapidly extended in the United States to inpatient settings for acute psychotics and later to the treatment of adolescent drug addicts in residential settings. Therapeutic community approaches are now being proposed and evaluated for juvenile delinquents, criminal offenders, parolees, and other deviant groups.

Implicit in the ideal of therapeutic community is a belief in the human potential for change. This potential is to be sought not only among the professional and nonprofessional staff, but also among the patients, inmates, and clients themselves.

The therapeutic community movement within mental health institutions has parallels in the innovative outpatient psychotherapy and counseling proposed in recent years. There are many similarities between the group techniques employed by the therapeutic community and the expressive techniques of encounter groups, Gestalt therapy, primal scream, and other new forms of psychotherapy. Applied to institutional settings, these techniques have had early success in psychiatric units with large numbers of adolescents or young adults. They have also been applied in self-help residential treatment settings for drug addicts such as Synanon, Daytop, and Phoenix House, and they are now being tried in peer programs for offenders and delinquents.

As Gruenberg (1966) has pointed out, these new "technologies" had impact on chronic as well as acute patients. The new psychosocial techniques improved care for people with chronic, severe mental disorders and often changed the organization of treatment into a pattern called community care. The anticipated benefit of this new technology was the prevention of chronic deterioration in personal and social functioning. While probably less effective in rehabilitating people who have already developed chronic deterioration in mental hospitals, psychosocial approaches are nonetheless of help to some chronic patients.

Therapeutic community practices tended, in several ways, to preserve the patient's sense of self-respect and feeling of responsibility for his own behavior. Locks and other physical restraints were eliminated. Patients were discharged as soon as the admission-related crisis was resolved. Early release policy facilitated easy readmissions whenever the clinical, personal, or family situation demanded it. When timely readmissions were resisted, however, rejecting attitudes toward difficult
patients tended to develop and community placements became difficult or impossible. The hospital staff's caseload came to include increasing numbers of patients in the community where consultations with patient, family and community physicians, nurses, social workers, and police led to a blurring of boundaries between the mental hospital and the "real world."

Some community mental health programs already were operating when the first new drug was discovered in France in 1952. In the mid-1950's the United States began to import the new drugs from France and new psychosocial techniques from Britain. As was mentioned above, because the new drugs made therapeutic community and community care practices easier, some assumed that all subsequent changes in treatment and outcome had been caused by the drugs.

About half the patients at risk of developing chronic syndromes are schizophrenic; the other patients at risk represent multiple diagnostic groups. According to Gruenberg (1966), the introduction of widespread community mental health practices reduced the number of occupied hospital beds by about 50 percent in 10 years. This drop occurred despite rising numbers of first admissions and readmissions, because the length of stay following admission had dropped even more dramatically. In Dutchess County, N.Y., half of all admissions since 1965 have been released within 2 weeks. Good research data show that community care for seriously ill patients (ages 16 to 65) reduces the frequency with which chronicity occurs from over 40 per 100,000 general population to 16 per 100,000 per year.

**Improved Outlook for the Acutely Ill Patient**

Although some professional and ideological tension existed, and still persists, between psychopharmacologists and social psychiatrists, in practice the two forms of technology are readily combined. The net result has been to greatly improve the outlook for the treatment and care of acute episodes. This process has had effects beyond the needs of individual patients: Professional confidence has increased, public attitudes have changed, the care of the mentally ill has been rapidly absorbed into the general health care system, and the public monopoly on mental health services has been altered and replaced by an emerging pluralistic, diversified system.

The carefully controlled research studies undertaken to establish the feasibility, efficacy, safety, and cost efficiency of these new treatment approaches are worthy of special note. In the early 1960's, a number of very ingenious research projects were undertaken to investigate the combination of drug and psychosocial treatments. These studies demonstrated, for example, that day-care treatment is an effective alternative to inpatient care for many patients. The most notable treatment study was conducted by Zwerling and Wilder (1962) at Albert Einstein Medical School and indicated that as many as 80 percent of adult patients usually destined for inpatient hospital treatment could be treated in a day treatment program.

The studies also demonstrated that home treatment by nurses is another viable alternative to hospitalization. Pasamanick, Scarpitti, and Dinitz (1967) conducted a systematic investigation in Louisville and described in their important book, *Schizophrenics in the Community*, how intensive home treatment by visiting nurses, combined with medication, could prevent hospitalization and improve family functioning and rapid symptomatic reduction.

It also has been shown that early discharge is feasible and effective. The Veterans' Administration study was of crucial policy importance, as were the studies carried out at the Massachusetts Mental Health Center and Harvard Medical School by Greenblatt et al. (1965) in the Drugs and Social Therapies Project. Recent studies at the Langley Porter Neuropsychiatric Institute of the University of California at San Francisco (Glick et al. 1976) and at Columbia University (Herz, Endicott, and Spitzer 1975 and Hertz et al. 1971) have confirmed the value of brief, intensive hospitalization for acute patients, including schizophrenics.

**The Radical Solution: Decarceration and Deinstitutionalization**

Attempts at internal reform, even when successful (as with the therapeutic community movement within the mental hospital), only partially silenced critics and skeptics. In the demands for redress of social grievances that characterized the 1960's, professionals like Thomas Szasz and R.D. Laing, jurists like David Bazelon, and public interest lawyers like Charles Halpern joined with spokespersons for the New Left, black militants, and even some right-wing conservatives in criticizing prisons and mental hospitals as being both ineffective and unjust. The remedy they suggested was radical: deinstitutional-
zation and the dismantling of these institutions. Decar-
ceration became the battle cry of the new abolitionists.

These critics argued that the ineffectiveness of the
total institutions resulted only in part from internal
social structure and its effect on otherwise noble attempts
at rehabilitation and treatment. They felt that such ef-
forts as building a therapeutic community within the
institutions were only partial solutions. Even innovations
such as combining drugs and psychosocial methods were
criticized as palliative and simply as further means to
induce conformity and social control of deviance. Critics
asserted that the feature of total institutions that fore-
doomed them to inescapable failure was their relation-
ship to the larger society—i.e., their status as “double
agents.”

Modern total institutions claim to be committed to
both social control and personal change; yet whenever
conflicts arise between the two goals, the social control
mandate takes priority over rehabilitation. This appar-
ently will go unchanged so long as public mental hospitals
are under the legal aegis, administrative control, and
fiscal dominion of the larger society, whose legislatures,
commissions, and agencies have as their highest priority
the controlling of deviance rather than the meeting of
the needs of the individual client.

The radical reformers proposed the abolition of total
institutions, particularly those employing involuntary
commitment and involuntary treatment, and suggested
they be replaced by alternative forms of voluntary treat-
ment for the mentally ill and community correction for
offenders.

Deinstitutionalization and Community Mental
Health Programs: The Policy Innovations
of the 1960's

In the mid-1960's, the social psychiatric reformers,
radical critics, civil libertarians, and conservative budget
advisors united to support deinstitutionalization policies
in state and local mental health programs. While their
theoretical rationales differed dramatically, with antici-
pated outcomes varying according to ideology and
rhetoric, these diverse groups developed a short-lived
consensus on the policy of early discharge of acute
patients and community placement for long-stay hospi-
talized patients.

It is interesting to note that while earlier research ef-
forts had documented the value of short-term hospitaliza-
tion and alternatives to hospitalization for acute episodes,
the most far-reaching public policy implications dealt
with chronically hospitalized patients in large public
mental institutions. In the second half of the 1960's,
almost every state's department of mental health began
a policy of systematically discharging previously chroni-
cally hospitalized patients. Yet there was little research
evidence to support this policy. The state that has gone
the furthest in this respect is California. A number of
professional meetings have been held recently to discuss
the closing of state hospitals (Greenblatt) and numerous
observers have predicted the demise of the state hospital
system. Massachusetts, for example, has already closed 3
of the state's 12 hospitals, and plans are underway for
the possible closing of 2 more. Nationwide, there also
has been a major reduction in the number of patients
resident in mental hospitals.

To some extent these figures are deceptive. Kramer
(1969) has pointed out that a major proportion of the
reduction in the number of resident patients in public
mental hospitals is accounted for by the movement of
elderly mentally ill patients from mental hospitals into
nursing homes. This clearly accomplishes an improvement
in mental health statistics (i.e., by lowering the census of
mentally ill patients). It also probably contributes to an
improvement in the fiscal condition of the budgets of
state departments of mental health since the burden of
care is shifted to Medicare and other Federally supported
programs. Whether community placement contributes to
the quality of life and longevity of the patients involved,
however, is not clear. There are even suggestions that the
opposite is true—that mentally ill patients transferred to
nursing homes have fared poorly due to fewer opportuni-
ties for socialization and recreation, less sophisticated
use of medication, a possible increase in mortality due to
the psychosocial and psychobiological trauma of transfer
itself, and the uneven if not poor quality of medical care
in the majority of nursing homes.

Independent of the reduction in patient census attrib-
uted to the shift to nursing homes, there is no doubt that
a large proportion of the population decrease was ac-
counted for by administrative actions leading to discharge
of many patients into the community. This policy of
deinstitutionalization of chronic patients has generated
the most controversy. While research evidence supporting
the policy of deinstitutionalization with regard to
chronic patients is hard to find, excellent studies exist
on brief hospitalization for acute episodes and on com-
The right-wing fiscal conservatives were interested in re-shifting the fiscal burden of responsibility to the Federal rather than state or local funds. Allied with the fiscal conservatives were the civil libertarians, who were horrified by depersonalization, lack of treatment, and opportunities for abuse of power in the large institutions. In addition, the popular press and media depicted the public mental hospital as a snake pit in such offerings as the recent film, “One Flew Over the Cuckoo’s Nest.”

The policy of deinstitutionalization also served to confuse some issues. Mental institutional censuses did drop coincident with the development of community programs, but this was probably because the widespread practice of rapid discharges shortened hospital stays even faster than the unfavorable consequences of de-institutionalization raised admission and readmission rates. Deinstitutionalization and the associated drop in institutionalization, it would seem, became a slogan and a de facto policy decision based on limited research evidence.

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The mental health care system has changed markedly as a consequence of new technology, shifts in community attitudes, altered professional practices, and changing public policy. The combined effect of these developments has been to diversify and deinstitutionize a...
system of mental health care that was, as recently as 1950, a public monopoly in which services were delivered almost exclusively in the setting of a large public mental hospital. There are few areas in health or social welfare where significant structural changes have occurred as rapidly and as widely as in the mental health field.

Extensive studies by Kramer (1976) and his associates at the NIMH Division of Biometry and Epidemiology have documented significant nationwide shifts in patterns of care for acute schizophrenia. There has been an overall reduction in the duration of hospitalization for acute episodes, an increase in the percentage of acute schizophrenic patients discharged within 6 months to 1 year, and a shift in the locus of treatment for schizophrenia from large public hospitals (state, county, and VA) to community-based programs, particularly community mental health centers and psychiatric units of general hospitals. These nationwide data indicate that new technology, psychoactive drugs, and the availability of community facilities have changed patterns of care in the following important ways:

1. The average daily census of public mental hospitals has decreased dramatically over the past 15 years so that it is currently between 40 to 50 percent of its 1954 peak.
2. There has been a rapid expansion in outpatient and ambulatory services of all sorts—e.g., private, public, adult, and child.
3. Inpatient care episodes per 100,000 population have remained fairly stable in the past 20 years at about 800 episodes per 100,000 population. The dramatic increase in utilization of mental health services has come in the area of outpatient care.
4. There has been a marked shift from use of public institutions to use of those in the private sector. Even with regard to inpatients, the public mental hospitals now only account for half of all episodes of inpatient care, whereas in 1952 they accounted for 80 percent of all care episodes.
5. Public acceptance of the concept of mental health has grown, evidenced by a dramatic increase in the use of mental health services and an expansion in the definition of personal, family, and social problems considered under the rubric of “mental health.” This has led to a controversy over the limits of the therapeutic ethos.

6. Psychiatric services, both inpatient and ambulatory, have been increasingly accepted under the various health insurance programs. Although widespread, this coverage is not nearly so extensive as had been hoped for by the proponents of community treatment.

The sum total of these trends has been a shift from inpatient to ambulatory care, from institutional to community settings, and from the public to the private sector (Kramer 1969).

Within the mental health field, these reforms have had significant success. In contrast to the prisons, where populations and internal discontent are growing, mental health institutions have seen a reduction in resident population and a radical restructuring of their delivery system. The relative place of the public mental hospital in the overall mental health delivery system has changed. The majority of mentally ill patients are now being treated as outpatients. In 1950, 80 percent of all mental health episodes were treated in public hospitals; today, the public hospital provides the minority of treatment episodes. For inpatient treatment, psychiatric units in general hospitals and private hospitals, rather than public mental health institutions, are now the settings for the majority of admissions.

The mental health system has experienced a major shift from almost total reliance on a system of involuntary incarceration and treatment in public institutions to a voluntaristic and pluralistic system. The system is voluntary in the sense that increasing numbers of patients have the choice of applying for treatment via their health insurance and pluralistic in the sense that patients have more options as to the type of treatment they will receive.

No longer is the mental health system a state-owned and-operated monopoly, as is still the case with correctional institutions. In the health field, the availability of increased numbers of individual practitioners, nonprofit hospitals, and voluntary agencies has greatly increased the number of treatment alternatives. The availability of the voucher system, in the form of health insurance, has given the individual patient and his family increasing degrees of freedom.

The Dilemmas of Partial Success

We have come to the end of an era in our society’s attempt to deal with mental illness. For over 100 years,
we have been guided in our efforts by the utopian vision of the “good” mental institution and have attempted to separate the “bad” patients from the “mad” ones. We have held the “bad” ones responsible for their actions and, consequently, these have been judged by the criminal justice system. The “mad” we have labeled “sick” and in need of treatment; we have expected them to be unresponsive to the usual mechanisms of social control, particularly punishment. For both categories of deviance, the “bad” and the “mad,” we have attempted to create institutions that would simultaneously provide incarceration and treatment. We have tried to satisfy the needs of two constituencies—those of the society at large, which has demanded retribution and restriction of the physical movement of deviants, and those of the mentally ill, who require rehabilitation.

For the mentally ill, at least, the illusion of the good “total institution” is being abandoned and community programs are rapidly replacing mental institutions. Internal reform and reorganization of the mental institution in itself will produce only limited and short-lived change. The real changes that have affected the destiny of the mentally ill have come either through the introduction of new technologies (e.g., the use of psychotropic drugs) or the development of new social policies (e.g., the community mental health program).

This movement out of the mental hospital and into the community has created a number of new problems and dilemmas:

- Adverse neurological complications of potent drugs
- Limited availability of psychosocial technology
- A demand for social control
- New forms of chronicity
- Ambivalence toward new technology.

The Adverse Neurological Complications of Potent Drugs—Tardive Dyskinesia

In addition to the misfortunes that had already beset the chronic schizophrenic, we have now also witnessed the emergence of tardive dyskinesia. This side effect involves involuntary muscle movements of the face, mouth, shoulder, and arm in patients who have been receiving antipsychotic medication for long periods of time. One of the problems in dealing with tardive dyskinesia is that it is not possible to tell at the beginning of treatment which patients will develop this side effect or when and how it will manifest itself.

Physicians in general have long been experienced in dealing with the “cost-benefit” analysis—the trade-off between the therapeutic benefits of drugs and the dangerous side effects they produce. Only recently, however, have psychiatrists had access to therapeutic agents powerful enough to make facing this dilemma unavoidable. It is interesting to note how seldom this problem is discussed by psychotherapists, either because they really do not believe that their treatments are powerful enough to cause adverse consequences or because they are reluctant to face the fact that psychotherapies may have extremely adverse consequences, such as suicide. One recent study (Lieberman, Yalom, and Miles 1973) dealt with various psychotherapies and the extent to which they produce certain kinds of casualties.

In dealing with treatments that may have deleterious consequences, an important question inevitably arises: How does one obtain truly informed consent? Who should make the decision—the patient? the psychiatrist? the relative? the hospital administrator? or some legal ombudsman appointed to act as the patient’s advocate?

A case vignette may illustrate the interplay of problems that can arise when one opposes patients’ rights with those of the society at large.

D.Y. is a 23-year-old unmarried white female who has been psychotic almost continuously since age 16. She has been hospitalized in numerous state and private hospitals with only a brief period of remission. Frequent periods of assaultiveness, pacing, confusion, auditory hallucinations, and disheveled dress have occurred. About the sixth year of her hospitalization it was noted that she began to develop periorbital mouth movements and smacking movements of the lips, generally considered early signs of tardive dyskinesia. Her medications were discontinued and her psychotic behavior became more florid. The staff was caught in a dilemma. During the period when medication was withdrawn, the patient became very psychotic and attacked a nurse on the night shift, attempting to strangle her. Only the fortunate intervention of another patient saved the nurse from death by strangulation. The decision was therefore made to reinstitute medication. Was the patient capable of participating in this decision? Was the decision made in the patient’s best interests or to control her aggressive behavior? Was this done for the patient’s benefit or to improve staff morale?
The patient in question was too psychotic to be competent to make such decisions and had no family. Massachusetts recently passed a law establishing mental health legal advisors; under the new system, the appropriate procedure to be followed in the case described above may possibly have been to approach the legal advisor with a request to reinstitute treatment on the basis that the patient was not competent to give truly informed consent. The question then arises whether at that point the patient's legal advisor should make the decision or whether the issue should be shifted to a court where the balance between the patient's rights and needs could be weighed against those of the staff and the other patients.

The usual commitment laws do not address themselves sufficiently to this problem since the distinction between commitment as involuntary hospitalization and involuntary treatment has not yet been fully clarified in the courts.

The Limits of Psychosocial Technology

Some dilemmas are caused by the limits of psychosocial technology. While sociological studies have indicated the dehumanizing and depersonalizing aspects of large mental hospitals, with their bureaucracy, authoritarian structure, and rigid caste barriers between staff and patients, corresponding attempts to develop effective interventions of a social and therapeutic nature have had only limited efficacy. Programs such as group therapy, individual psychotherapy, milieu therapy, and sociotherapy, while hailed with great enthusiasm by proponents such as Maxwell Jones and others, have not achieved the improvement in patient functioning that had been expected. In fact, it should be noted that many of these innovative social therapies are first advocated for schizophrenics, but are eventually used to treat such adolescent problems as drug abuse or personality disorder. It is as if the innovators and practitioners of social therapies, faced with the intractability of chronic schizophrenia and the limited responsiveness of patients to the available techniques of social therapy, shift their target populations in the hope of finding populations more responsive to their interventions.

The Demand for Social Control

The mental health field is now experiencing a backlash. Many local communities and neighborhoods are against the placement of halfway houses, community residences, and day programs in their area. While resistance to the placement of patients in the community had been anticipated, an unexpected consequence of deinstitutionalization has been the emergence of new forms of chronicity. The living conditions of ex-mental patients existing untended in such “community settings” as seedy rooming houses or hotels are disturbingly reminiscent of those found in the worst of the old-time “snake pits.” We are learning to our dismay that back wards can be created in the community as well as in the “total institution.”

These reflections upon backlash and chronicity as problems for community mental health are intended to place current controversies in some perspective. We do not know how to gauge the capacity or willingness of the larger society or of individual communities or neighborhoods to tolerate, accept, and integrate deviant behavior. In practice, the limits of community acceptance are determined by trial and error, with consequent periods of reform being followed by reaction and retraction, usually with a return to some form of institutionalization.

The ethical dilemma of the community psychiatrist comes from the pressures exerted upon him not only to reduce costs, but also to render the patients in the community less noxious and less socially deviant. Since many discharged patients are bizarre or atypical in their dress, inept in social functioning, and marginal in their economic productivity, there is often pressure (as alluded to above) to sequester them in welfare hotels in special neighborhoods. In negotiating for placing halfway houses and community residences, the path of least resistance is to locate such facilities in areas populated by the poor, and as a consequence, they are seldom placed in middle-class neighborhoods. These practices reinforce the social segregation of patients. The back ward is being replaced by the back alley. It is the poor, who are often black or members of other minority groups, who are the most burdened since it is into their neighborhoods that the ex-patients are placed by social agencies.
New Forms of Chronic Dependency

Unfortunately, when we assess current practices in community mental health, the picture is often bleak. As inadequate as research in this area is, the gap between existing research knowledge and actual practice is immense (Hogarty 1971 and Hogarty et al. 1973).

Research recently undertaken to determine the quality of life of schizophrenics still residing in public mental hospitals indicates the continuance of such appalling conditions as institutionalism, dehumanization, and de-individualization; regardless of the criticisms that may be leveled at Rosenhan's (1973) conclusions pertaining to diagnosis and the medical model (Spitzer 1975), we cannot ignore findings that document the impersonality of mental hospitals, particularly the staff's tendency to disregard the individual needs of patients. Although the census of state mental hospitals has decreased greatly, the quality of treatment in these facilities has not significantly improved. Available data indicate that patients residing in public mental hospitals are still subject to poor treatment and that the facilities still produce the phenomenon of institutionalization as identified by Goffman and other sociologists in the 1950's.

As mentioned above, the situation is little better for those patients in the community. New forms of “community chronicity” have been developed in many large urban areas such as New York City, Chicago, Los Angeles, and San Francisco. In the absence of an adequate network of aftercare facilities, community residences and halfway houses, sheltered workshops, or day treatment centers, large numbers of patients are relegated to “lives of quiet desperation” in welfare hotels in segregated neighborhoods. They are subsisting on minimal incomes from social welfare or disability payments, and receiving poorly monitored, often poorly prescribed, psychotropic medication. When comparing this picture of a large number of schizophrenic patients with the potential that had been demonstrated in the imaginative research programs of the 1950's and 1960's, one is appalled and dismayed. Research studies such as those by Gruenberg (1966), Fairweather et al. (1969), and the Fountain House group in New York indicated that the combination of antipsychotic drug medication and the availability of a network of properly supervised rehabilitative, vocational, and residential facilities could reduce the disability and social isolation of schizophrenics.

The high promises of the community mental health program have only been partially realized. Application of available knowledge failed to materialize except in a few selected community mental health centers. Perhaps the mental health movement became overly ambitious in the late 1960’s, too quickly expanding its list of concerns to include alcoholism, drug abuse, racism, and social unrest, before being sure that the need to solve the problems of schizophrenics—one of our primary clinical obligations—had been fulfilled.

Perhaps there has also been a failure on the part of the NIMH to assign priority and resources to this need, or perhaps there has been an overestimation of the extent to which community attitudes have, in fact, changed. Whatever the reasons, the community treatment of schizophrenia remains an area of high relevance, but low success.

Psychiatrists, like their colleagues in internal medicine and neurology, have effective technology that makes the patient better but not well. The patient is better enough to be outside of the institution but not well enough to be fully self-sufficient. The patient is often left with residual mental impairment in speech and cognition, and with social liabilities which leave a moderate percentage of discharged chronic patients unable to enjoy a full independent existence, but instead requiring some degree of social support—e.g., welfare or disability payments, special residential placements, and social and recreational supervision, usually in day programs.

This situation has led to concern about the quality of life for patients in the community. Newspaper reports in most major cities, particularly New York, Chicago, Boston, and Los Angeles, have documented the fact, that for a significant number of patients discharged from the hospital, the quality of life is at best marginal. Similar research in California (Lamb and Goertzel 1971 and Wolpert, Dear, and Drawford 1974) has led to the same conclusion.

Patients often live under conditions of minimum supervision and poor drug management, so that they often may be over-drugged, heavily sedated, stuporous, or dulled. Their limited ability for social interaction means they often wander the streets or sit aimlessly looking at television. In contrast, it is often claimed that if they were on the grounds of a state hospital, they would have access to various recreational facilities and group activities. In cities, particularly inner city neighborhoods, they are often at the mercy of various predatory groups,
such as youth gangs and criminals, and are subject to beatings, robberies, and various forms of abuse.

The essential question here is not whether the patient in the community is “better off” than the hospitalized patient, it is the moral issue of whether or not he is being given a choice in the matter.

The pressure to discharge patients from mental hospitals is extremely great. Numerous administrators have described the basis of this pressure as budgetary considerations and the wish to see the hospital censuses reduced. Again, however, the ethical question arises: Are we in a position to offer patients a choice? The issue of choice applies not only to the patient but also to the psychiatrist and to other mental health professionals. Do they really have the ability to choose among various alternatives in deciding what is best for the patient?

An unstated corollary of the observation by Goffman (1961) and others on mental hospitals and other total institutions is that the opportunities for individual freedom are greatest in a social setting where one can choose which of many social roles will be played, with which individuals, and in what locales. Thus, the large modern city, with its opportunities for multiple personal groupings and freedom of movement, potentially offers far more individual freedom than the small rural village or the commune. However, in the modern city, we also find counterforces that tend to limit individuality. The price for this potential freedom of choice is often actual social isolation, personal loneliness, and anomie that characterizes too much of modern urban life for many, especially the poor, marginal, and mentally ill. Thus, for the mentally ill the city may generate psychological consequences similar to those produced by a total institution, and one of the unintended consequences of deinstitutionalization may be new forms of anomie and isolation for the chronic and dependent ex-patients, who are “in” but not “of” the community. This point is not made to promote the practice of reinstitutionalization, but rather to lay at rest any remnants of the romantic notion that the mentally ill patient loses his distress or becomes less deviant on discharge.

Our Ambivalence Toward New Technology

One of the main theses in this paper has been that widespread changes in public policy and the mental health care system have been determined to a great degree by recent advances in biological and psychosocial technologies. Accordingly, further progress toward deinstitutionalization and community treatment is likely to depend upon new technologies.

Here our attitudes are ambivalent—we want new technologies, but fear them. We are also undecided as to what modes or degree of regulation should be exercised over the development and application of behavior control technology. Mental hospitals and community programs can be expected to make increasing use of new physiological and psychological techniques in pursuit of their stated goals of immediate behavior control and long-term behavior change. Incarceration, of course, brings immediate behavior control by restricting the movement of the deviant individual. Recent technology had promised that newly learned personality skills and attitudes would endure; that when the individual returned to the larger society, his behavior would in fact be changed, not merely controlled. For many patients this has not been true. In many instances change has become dependent on the continued use of potent drugs. The hope of permanent rehabilitation has been countered by reservations about the manipulative capacities of the new techniques. The current impetus for regulation has come from within the professions and from groups concerned with bringing the principles of civil rights and personal liberties to bear on the functioning of the mental health system.

Over the past decades, the recognition that total institutions were failing the goals society set for them—indeed, that their intrinsic structures tended to undermine their avowed purposes—has spurred three kinds of change: (1) internal reorganization which has promoted greater personalization and the “therapeutic community”; (2) advocacy and some measures toward deinstitutionalization; and (3) the introduction of new techniques of behavior control, capable of both enhancing individual change and permitting release from closed institutions. Reforms of the first two sorts have been made more possible by the last, but, paradoxically, technology has generated its own new problems. Without social regulation, the threat technology poses may be unacceptable to society.

 Appropriately, at a time when new technologies are emerging, civil libertarians and other critics are becoming more and more concerned about the ethical aspects of their use. Until these issues of rights, due process, and appropriate mandates are settled, the full potential of
drugs, behavior modifications, and other treatments for enhancing the individual freedom and social cohesion of the patients cannot begin to be realized.

The fear is that drugs and other behavior control technologies, if not controlled and regulated, combined with the anomy and isolation of urban life, will convert our communities into the ultimate total institution, a totalitarian society. Thus, we are faced with the visions—or nightmares—of 1984 and A Clockwork Orange. The dilemma is that without new technologies, long-term changes in the mental health system are unlikely, and the creation of new community alternatives will depend upon the availability of new technologies. Thus, the issue of community treatment of the mentally ill is not only scientific and professional, but also social, ethical, and political in the broadest and most humane sense of those terms.

References


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american orthopsychiatric association annual meeting

The 55th Annual Meeting of the American Orthopsychiatric Association will be held March 27-31, 1978, at the Hilton Hotel in San Francisco, Calif. The theme for this year's meeting is Boundaries of Mental Health. The meeting will focus on the mental health professions—their relevance to the consumer of mental health services, and their implications for practice. Ortho is a multidisciplinary organization and all members of the mental health professions are invited. For information write: American Orthopsychiatric Association, 1775 Broadway, New York, N.Y. 10019. Phone: 212-586-5690.