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Abandonment of Responsibility for the Seriously Mentally Ill

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As ROSE NOTES IN HIS ASSESSMENT of the present crisis in the care and treatment of people with severe chronic mental disorders,

> the rhetoric of deinstitutionalization seems to mask a brutal political and economic reality—the general abandonment of mentally disabled people. . . [T]he new policy has brought with it a new set of mental health problems, including massive numbers of people needing rehospitalization; gross inadequacies in community resources for aftercare and rehabilitation; large-scale scandal, exploitation, and abuse in the new industry of operating community facilities; increased drug and alcohol dependency among released patients; and an apparent social and psychological decay among patients released into nursing homes, adult homes, or "welfare" hotels.

We concur with Rose that these conditions attest to an abandonment of the seriously mentally ill, and that community psychiatric services fail to meet the needs of many patients discharged from state mental hospitals. Rose is correct in pointing out that political and economic considerations weigh heavily in this abandonment, but to assess the present crisis in terms of "deinstitutionalization" rhetoric will not help us to understand it.

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The term "deinstitutionalization" is sometimes used to refer to the continuous decline in numbers of patients resident in state mental hospitals in the United States since 1955. But this decline started as the result of improved treatment in state mental hospital programs, and took on the characteristics of abandonment only in the last decade or so. Even at their worst, the state mental hospitals provided a last resort for one class of society's rejected population. But today, no agency of government—local, state, or federal—is taking comprehensive responsibility for providing psychiatric and social services for chronically mentally ill patients. To understand why the present crisis of abandonment exists at a time when public investment in mental health has never been higher, we will trace the historical development of the abandonment of responsibility for the seriously mentally ill that state governments assumed in the nineteenth century by making them wards of the state. We focus particular attention on New York State, which, because it pioneered most of the legislation and changes in mental health services affecting the state mental hospitals, typifies the processes leading to the present nationwide crisis of abandonment.

The Rise and Decline of State Responsibility for the Seriously Mentally Ill

At the end of the eighteenth century, Dr. Philippe Pinel transformed two Parisian madhouses, the Bicêtre and the Salpêtrière, into hospitals for treating the mentally ill. He replaced chains with "moral treatment," which was designed to supply the personal needs of psychotic patients and to arouse their dormant faculties for self-care. Simultaneously in England, a group of Quakers led by William Tuke founded the York Retreat, where they eschewed all restraints and treated their own mentally ill with kindness, "plain talk," and honest efforts to understand and diminish their distress. In the United States in the early nineteenth century, the successes of Tuke and Pinel impressed a number of physicians and social reformers who succeeded in establishing some hospitals based on these models, such as the Hartford Retreat and the McLean Hospital. The high rates of recovery claimed for the small, moral-treatment institutions, in which patients of independent means were seen daily by the

superintending physician, produced a "cult of curability" that helped to launch the state mental hospital movement in the United States (Deutsch, 1937).

The Mentally Ill Become Wards of the State

In 1841, when Dorothea Lynde Dix began her crusade on behalf of the mentally ill, there were only eighteen hospitals (state or private) in the United States devoted exclusively to the care of the insane; the vast majority of such cases were in jails and poorhouses, kept at home, boarded out, or auctioned off to the "lowest bidder" (Hamilton, 1944). Echoing Horace Mann's 1828 plea that the insane be declared "wards of the state," Dix convinced the Massachusetts legislature that local communities had shown themselves incapable of caring for the insane. Like other such reformers, she did not hesitate to reinforce her arguments with the economic lure that decent treatment in state hospitals—small and geographically isolated from the stresses of daily life—would cure insane people quickly, making them productive members of society instead of drains on the public purse. In 1843, the legislators voted that all the poor and indigent mentally ill were to be made wards of the Commonwealth of Massachusetts, and to enlarge Worcester State Hospital, established as a result of Horace Mann's efforts a decade before.

The Dix-Mann doctrine that the mentally ill are wards of the state reached its most explicit expression with the passage of the New York State Care Act of 1890. This legislation provided for removal of all the insane from local poorhouses and jails to state hospitals, where they were to be supported and treated at state expense, and it required each state hospital to admit all cases of insanity in its district, regardless of prognosis. Following its inauguration in New York, state after state adopted the Dix-Mann principle of complete state care for the seriously mentally ill (Deutsch, 1937).

Although some state hospitals in the United States were established explicitly as custodial institutions, most attempted to apply moral treatment, and some closely approached that ideal (Dickens, 1842). However, even the best managed hospitals did not long continue to function as the small, rural, therapeutic retreats that Dix and Mann had envisioned. New asylums were built as older ones overflowed, and the demand for accommodation always seemed to exceed capacity. As chronic cases accumulated and new admissions

rose, overcrowding led to a deterioration in the standards of care. The "cult of curability" yielded to the notion, "Once insane, always insane"; moral treatment precepts were forgotten, and patients' behavior was controlled with physical restraints and seclusion.

The Development of Community Psychiatric Services

Shortly after the turn of the twentieth century, Clifford Beers described his hospitalization as a mental patient in *A Mind That Found Itself* (1908). This book helped to focus public attention on the plight of the mentally ill. The National Association of Mental Hygiene, founded in 1909 with Beers as president, was born in a climate of intense social reform activity that included passage of legislation to protect women and children, movements to abolish slums and to provide decent housing for the poor, and attempts to make fuller use of public health principles (Deutsch, 1944). A major aim of the association was to improve the care and treatment of mental hospital patients. But the mental hygiene movement, especially after World War I, turned its attention to prevention by early detection and treatment of mental disorders, a strategy exemplified by its active support for the development of child guidance clinics and parental education (Woodward, 1948). The leaders of the mental hygiene movement were sincere in their belief that such measures would reduce the need for mental hospital treatment. In hindsight, however, it is clear that the child guidance clinics were treating, as best they could, a new set of problems that had not before received psychiatric attention—disorders of childhood. They enlarged the spectrum of cases receiving attention; but they were not arresting later psychoses through early effective treatment on a significant scale.

The rapid growth of child guidance clinics and other outpatient psychiatric services after World War I marked the beginning of organized community-based psychiatry in the United States, which had begun in the late nineteenth century in Europe. There, Jean Charcot, Pierre Janet, Hippolyte Bernheim, and others developed a new type of psychiatry centered around the psychiatric university clinic, treating primarily neurotic disorders that did not ordinarily require care in a mental hospital (Ellenberger, 1974). But it was Sigmund Freud who most significantly redefined the office psy-

chiatrist's role, as that of a psychotherapist who helps the patient to struggle against his disordered functioning, rather than that of a doctor who diagnoses it and prescribes treatment. Freud also evolved the principle that, like a music teacher charging by the hour, the therapist sells his time, knowledge, skill, and attention. This put the office practice of psychiatry on a commercial basis. This approach was imported to the United States in the 1930s with the migration of hundreds of psychiatrists from Nazi Germany. Many of them were private practitioners and they were welcomed into university medical school departments of psychiatry that had been striving to develop dynamic, psychoanalytically oriented services as a result of Adolf Meyer's influence. This amalgam of university psychiatry and psychotherapeutic office practice laid the foundation for psychiatric careers unconnected with state mental hospitals.

The Precursors of Abandonment

During World War II, university-trained psychiatrists serving in the armed forces substantially upgraded the status of psychiatry. They served on draft and discharge boards, and they successfully treated many soldiers with emotional disturbances incurred under fire, rapidly restoring them to combat fitness. Immediately after the war, bolstered by optimism that their successes in treating combat emergencies could be applied to reduce the amount of mental illness in civilian life, these university-trained psychiatrists launched a campaign to obtain federal moneys to expand community mental health services and psychiatric manpower outside of state mental hospitals. The nation was receptive. The large number of young Americans rejected by draft boards or discharged from active duty on neuropsychiatric grounds aroused widespread concern about the problem of mental illness. Conscientious objectors working in the state mental hospitals, to relieve the critical wartime shortage of regular attendants, provided material for exposés of the poor conditions existing in many of them (Deutsch, 1948). Overcrowded and undermanned at all staffing levels, the state hospitals were nevertheless receiving a larger number of patients every year.

In the summer of 1947, Congress passed the National Mental Health Act of 1946, which created the National Institute of Mental Health (NIMH). Besides providing research and training grants, it provided formula grants-in-aid to states to develop community-

based psychiatric services. To qualify for these grants, each state was required to designate a mental health authority to receive the funds and to plan for and govern their disbursement. None of these funds could be used for the care of mental hospital patients. The belief that these newly created community psychiatric services would reduce the use of state hospitals is apparent in testimony given during the hearings on the 1946 bill. Robert Felix, then chief of the Division of Mental Hygiene of the Public Health Service, and later the first director of NIMH, stressed the importance of outpatient psychiatric clinics as "an effective means for the provision of early diagnosis and [saving] the states money by permitting earlier release of patients from mental hospitals" (Felix, 1946: 107).

Although this legislation did not directly undermine the budgets of state hospitals, it did nothing to relieve their problems, and it had two important consequences for the seriously mentally ill under their care. First, the federal moneys made available under the act rapidly expanded the number of university-trained psychiatrists and of opportunities for their employment outside of state mental hospitals. These hospitals, which provided the bulk of psychiatric training before World War II, could not compete with the universities for the most highly qualified residents. Also unable to compete with private practice and community-based settings for staff, the state mental hospitals never recovered the loss of leadership they sustained during the war. Second, Felix's argument that these community psychiatric services would "save the states money" was no help in getting state appropriations. Not only was it a false argument, but also it created an atmosphere of antagonism between state mental hospital psychiatrists and NIMH.

In 1949, New York State established an interdepartmental mental health commission as its mechanism for administering the moneys made available under the National Mental Health Act of 1946. The commission was also charged to develop a long-range plan for community mental health services and received an appropriation of state funds. The New York State Community Mental Health Services Act of 1954 was the result of this planning. This legislation authorized the development of local-government mental health boards to plan and establish services, and a permanent system of state financing of up to 50 percent of the total costs of local programs. The act declared four types of services eligible for reimbursements: 1) outpatient psychiatric clinics; 2) inpatient psychiatric

services in general hospitals; 3) psychiatric rehabilitation services for persons suffering from psychiatric disorders; and 4) consultation and educational services.

By returning some of the responsibility for operating mental health services to local governments, the New York Community Mental Health Services Act of 1954, which was soon adopted in various forms by many other states, marked the first move away from the Dix-Mann state-ward concept of complete state care for the seriously mentally ill. When the state hospital systems were created by state legislatures in the nineteenth century, they removed from local governments the authority to arrange local care. Because local government was charged with incompetence and corruption in its care of the insane poor and the insane jailed, the states—which are sovereign in our federal form of government—denied local government the authority to make such arrangements. Generations of psychiatrists trained in mental hospitals were indoctrinated with the notion that local governments could not be trusted. But in the 1954 act, the New York state legislature not only authorized local governments to develop inpatient psychiatric services (in general hospitals), but also undertook to defray part of the cost. The state no longer had a monopoly on hospitalized patients, and all seriously mentally ill people were no longer wards of the state.

The Development of Community Care for State Hospital Patients

During the same time period, when similar legislation for community mental health services was being passed throughout the country, news began to reach the United States about a new way of making use of mental hospital services. (These events took place before phenothiazines became well known in 1955.) Three pioneer British mental hospital directors (Duncan MacMillan, T. P. Rees, and G. Bell) tried to change the atmosphere in their hospitals by systematically removing locks from doors, removing restraints, and halting involuntary hospitalization. The pattern of hospital use changed. Long-term stays in the community, interrupted by short-term episodes of hospitalization in periods of crisis, replaced long-term hospital stays. The same clinical team of psychiatrists, nurses,

social workers, and attendants took responsibility for patient care during both community and hospital phases of care (Milbank Memorial Fund, 1958; Gruenberg, 1974a).

It is not easy for those without first-hand experience in mental hospital work to understand what a radical transformation this was. The early nineteenth-century mental hospitals were meant to be short-term, "moral treatment," humane, therapeutic havens. They were intended to replace asylums, which were long-term custodial madhouses, and from the available evidence, they did to a large extent (Bockoven, 1972). But by the end of the nineteenth century most of their beds were occupied by permanent residents with a very low probability of being released alive (Kramer et al., 1955). Custodial functions dominated their operations. "Aftercare" was given to patients "on parole" who showed promise of recovery sufficient to hope that they could be discharged within six months or a year. MacMillan, Rees, and Bell transformed aftercare into long-term care and made hospital episodes readily available in times of crisis. By 1954, half of their hospitals' case load was living outside the hospital, so that the hospitals' psychiatrists were spending half of their time caring for patients living in the community. The patients appeared to do dramatically better, showing less chronic troubled or troublesome behaviors. The reports of those British pioneers, describing how they had converted mental hospital practices into a new model of care and treatment, were looked on with suspicion by colleagues familiar with the intractable nature of long-term mental patients. Dr. Robert C. Hunt, who had had years of experience working in New York State mental hospitals, received a World Health Organization fellowship to study these British programs and, partly as a result of his meticulous and dramatic report, New York State Commissioner of Mental Hygiene Paul Hoch appointed a committee of hospital directors to visit them. Dr. Frank Boudreau, then president of the Milbank Memorial Fund, gave the label "Mission to Britain" to the foundation's grant to finance this committee's costs. The committee's reports received much attention. The new community-care, "open-hospital" pattern was a forerunner of what the hospitals should become if the symptomatic relief provided by the new psychopharmaceuticals was to be used constructively (Milbank Memorial Fund, 1960).

By the early 1960s, many state mental hospitals in the United States were operating as open hospitals, and some were providing

comprehensive services to most of their patients in the community. This movement toward *state-hospital-based community care* for the seriously mentally ill had little connection with the rapidly proliferating *community-based mental health services,* which rarely served people with severe mental disorders who often needed inpatient care.

The Federal Initiative

In 1955, Congress passed the Mental Health Study Act, which financed the Joint Commission on Mental Illness and Health, whose members were "to analyze and evaluate the needs and resources of the mentally ill in the United States and to make recommendations for a national mental health program" (Joint Commission, 1961: vii). In 1961, the Joint Commission published its report, *Action for Mental Health.* President Kennedy appointed a cabinet-level committee to analyze the report and to recommend legislative action, and Congress appropriated grants to the states to prepare plans on how they would implement the Joint Commission's recommendations.

According to Bertram Brown (1964), who participated in drafting the legislation and later became the third director of NIMH, the NIMH leaders responsible for providing guidance and direction to implement the report opposed what they considered to be its main emphasis on upgrading the state mental hospital system to a therapeutic level. Believing that a more radical departure was needed—something likely to cut the rate of hospitalization—NIMH personnel drafted legislation to create a system of community-based mental health services apart from the state hospitals. Deeply concerned that the NIMH strategy would mainly enlarge the spectrum of psychiatric cases receiving attention, and would not have a constructive impact on the long-term management of the seriously mentally ill, state mental hospital directors and state commissioners of mental hygiene tried to convince the federal government of the danger of undermining the staffing and budgetary position of the mental hospitals. The NIMH advocates won out with President Kennedy, who was also interested in developing a major initiative, by persuading him that the Joint Commission had been wrong in focusing on improving mental hospitals.

In his February 5, 1963, Message to Congress on Mental Illness and Mental Retardation, President Kennedy recommended a mechanism of federal funding for the creation of community mental health centers (CMHCs). Congress endorsed the president's "bold new approach" by passing the Mental Retardation Facilities and Community Mental Health Centers Construction Act late in 1963, which appropriated funds to construct this new type of facility on a grant basis. The CMHCs were to provide roughly the same network of services as those authorized under the New York State Community Mental Health Services Act of 1954, the fundamental difference being that a CMHC was to give all of a specified list of services if it gave any of them.

As Kahn (1969) points out, the notion that community psychiatry would reduce the need for state hospitals and would eventually replace them altogether is reflected in President Kennedy's message (1963: 6–7) on the CMHCs:

> Until the community mental health center program develops fully, it is imperative that the quality of care in existing State mental institutions be improved. By strengthening their therapeutic services, by becoming open institutions serving their local communities, *many such institutions can perform a valuable transitional role.* The Federal Government can assist materially by encouraging State mental institutions to undertake intensive demonstration and pilot projects, to improve the quality of care, and to provide inservice training for personnel manning these institutions. [Emphasis added]

Although invested in inpatient services for chronically ill patients, most state hospitals could have developed the four service components (inpatient; outpatient, partial hospitalization; twenty-four-hour emergency; and consultation and education) necessary to qualify for CMHC funding. But the first federal funds were authorized for construction of community-based new facilities, and state hospitals were not eligible. Moreover, the Hospital Improvement Program (HIP) and In-Service Training (IT) "transition" grants to mental hospitals (a maximum of about $100,000 per institution per year) were less than 10 percent of the funds authorized for community mental health centers, and less than 5 percent of a typical state mental hospital budget. But many state mental hospitals used HIP funds constructively to speed their conversion to

open hospitals and to develop hospital-based community care programs.

From Community Care to Community Neglect

By the late 1950s the open-hospital, community-care experiments of the pioneer British mental hospital directors were resulting in a reduction in mental hospital censuses. They also seemed to be contributing to an actual improvement in the behavior of long-term seriously mentally ill patients. The patterns of chronic disability, reflected in withdrawal and/or anger, which the reorganized services were thought to make less common, were labeled the "social breakdown syndrome" (SBS) (American Public Health Association, 1962). In order to test whether the reorganized services were responsible for lowering the frequency of chronic SBS (episodes of SBS lasting more than one year), a major evaluation study was conducted in Dutchess County, New York, in 1959, when a county service was organized at Hudson River State Hospital to provide services of humane, open-hospital care, combined with early discharge of patients to the community under supervision by the same hospital staff. Readmissions to hospital for short stays would be encouraged in periods of crisis in the course of the disorder (Hunt et al., 1961).

Dr. Hunt, who had become director of Hudson River State Hospital in 1958, realized that a hospital of over 5,000 beds, serving a district over a hundred miles long with many cities and towns, was not suited to letting the professional staff implement an early-release policy with long-term community care, interspersed with readily available crisis admissions. The size and scattered nature of the district and its hospital made such a pattern impossible. After analyzing this problem, Hunt concluded that although what he wanted could not be done for all his district, it could be done for the local county, where most of the population lived within a thirty-minute drive of the hospital. The hospital had been organized on the basis of specialized services (admission, disturbed, continued treatment, etc.). In a general hospital this type of organization has been called "progressive patient care." Hunt decided that specialized services were not the most efficient, and created a new service in which the patients were selected because they all came from the local county, Dutchess County. Hence a county service was created in a state

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hospital. A predominantly community-care, short-admission service rapidly developed.

Findings from the evaluation studies published in 1966 (Gruenberg, 1966) showed that the reforms resulted in more early terminations of acute episodes of SBS, and that they at least halved the number of episodes of SBS that became chronic each year. The studies also showed that the county services were no more effective in rehabilitating cases that had already become chronic than were the specialized continued-treatment services being provided to the other Hudson River State Hospital patients.

To those who had been watching these changes, it appeared not only that a more humane, efficient way of using psychiatric facilities had been discovered, but also that objective data had been provided, showing that this pattern reduced the amount of the worst burden of chronic mental illness measureably and significantly. No dramatic increases in cost were needed to implement such services, and other mental hospitals could learn the same lessons. But this was not to be. The efforts of state hospital directors in New York to apply these reforms extensively were gradually undermined by new legislation and administrative policies.

In 1964, a new Hospitalization Act was passed, which strengthened the ability of the New York state hospital staffs to provide comprehensive, hospital-based community care for chronic patients. All hospital districts were broken into smaller units and the hospitals were administratively reorganized into services assigned to care for patients from a district, on the model of the Dutchess County Unit. This pattern, known as geographical decentralization, had become a nationwide movement (Milbank Memorial Fund, 1962). In an effort to make state mental hospitals easier to enter and leave, and to bring them more under psychiatric control, the 1964 act also removed the power of courts to issue involuntary commitments to mental hospitals (patients whom the hospital had to accept). But New York's 1964 Hospitalization Act also removed another key feature of the Mann-Dix approach, since it opened the way for the state hospitals to reject applicants for care. This the hospitals gradually began to do after the 1965 amendments to the Social Security Act introduced Medicare and Medicaid. Although this legislation was planned with no recognition of what impact it would ultimately have on the care and treatment of the seriously mentally ill, these amendments led to a burgeoning of federally financed nurs-

ing homes to which the state mental hospital systems, under direction to reduce censuses rapidly, could discharge or transfer responsibility for large numbers of the elderly mentally ill. Rose and others (e.g., Kramer, 1977) have discussed in detail the important role of this and other federal legislation in expanding placements outside the mental hospitals for the chronically mentally ill and in extending disability payments for their support.

In 1968, the New York State Department of Mental Hygiene used the new admission laws passed in 1964 to implement a new policy of selective admissions of the elderly. Only those elderly patients thought able to benefit from modern psychiatric treatment would be admitted (Redick et al., 1973). The rest would be sent to sheltered living arrangements under supervision by welfare agencies, a policy reflecting a viewpoint expressed by a state planning committee (New York State Department of Mental Hygiene, 1964):

> Responsibility for arranging and providing sheltered living, temporary or permanent, for those with mental disorders who do not have the financial means to provide their own shelter should be carried out by public social welfare departments, and [t]here should be a planned and orderly transfer to [local] community mental health boards and departments of mental health of responsibility for aftercare of patients released from State hospitals.

This transfer of responsibility for long-term social care of patients to welfare agencies interfered with the ability of the hospital-based clinical team to provide long-term supervision and psychiatric care for patients in the community.

Gradually, more and more categories of mentally disordered individuals have been denied access to continuing care within the state hospital system. Today, it is hard for newcomers to the field of mental health and psychiatry to recognize the degree to which the state mental hospitals had been the last resort for mentally ill people who lacked extensive personal support.

The undoing of the Dix-Mann doctrine became official in May, 1972, when Governor Rockefeller signed into law a Recodified Mental Hygiene Law that "repealed the old Mental Hygiene Law that had been in effect since 1927, and that had retained most of the original State Care Act of 1890" (Forstenzer and Miller, 1975: 291).

Assessment of the Present Crisis

The deinstitutionalization policies leading to the dramatic reductions in state mental hospital censuses of the 1970s can be seen as a rapid acceleration of a trend to transfer financial responsibility for the chronically mentally ill patient from state mental health departments to the social welfare system. The present crisis of abandonment of the seriously mentally ill has arisen because no similar transfer of responsibility for their care and treatment has taken place. The erosion of state mental hospital responsibility has created a situation in which psychiatry's most helpless patients have no recourse against a general tendency of all medical services to reject their most unrewarding patients. While the seriously mentally ill are a visible problem causing much public concern, and espousing their cause has become a very gratifying role, the tendency has been to advocate solutions that are someone else's responsibility to execute. Social welfare departments are not equipped to provide the psychiatric attention that many of these patients need on a continuing basis. But such proposals as "remedicalizing psychiatry," and "mainstreaming the chronic mental patient into general medical practice" are simply code phrases for saying that psychiatry and the mental health facilities do not want responsibility for the seriously ill mental patient. Robert Morris has aptly described this "reject syndrome" as "a phenomenon in which service-providing agencies and families find it unpalatable or undesirable or unacceptable to expend the energy the mentally disabled require; and as a result, each finds a rationalization for trying to reject the giving of attention in the hope that some other organization or entity will assume the responsibility" (Morris, 1977–1978: 20).

The road leading to the demise of state responsibility for the seriously mentally ill and the current crisis of abandonment was paved with all the best intentions. Tragically for the seriously mentally ill, the current policies underlying the pattern of abandonment are based on erroneous interpretations of what patients need and what our current techniques can produce to help people with serious mental disorders. These interpretations have been systematically encouraged by a general crisis in government and social policy. The fashion has been for "cost-benefit" reasoning, dramatic efforts to reduce operating budgets, and shifting responsibilities away from

one element of government to another. Many of these errors are shared by both the advocates and the opponents of deinstitutionalization.

A Falling Mental Hospital Census Indicates Program Success?

The progressive technology that transformed many mental hospitals from primarily long-term-stay institutions, into hospitals in which an increasing proportion of beds were occupied by short-term crisis admissions (a median of two weeks), was common between 1955 and 1965. This progressive reorganization was accompanied by a rising readmission rate. But the shortened average length of stay led to a net drop in the number of beds occupied, so that the hospital census count dropped. During that period, a falling mental hospital census was a fairly reliable index of a mental hospital that was moving forward. But some policy makers grasped this index and decided that it was the goal. They tried to find ways to make the census drop faster. This makes about as much sense as a child's trying to push an automobile speedometer needle to make the car go faster.

A Rising Readmission Rate to Mental Hospitals Indicates Program Failure?

On the contrary. A policy of early release requires a policy of easy readmission. A falling census that occurs after the introduction of a progressive reform of community care, combined with short-term hospitalization as needed, is accompanied by a rising readmission rate. Early release from the hospital with continuing responsibility for patient care in the community requires a readiness to readmit when hospitalization is needed again. To refuse readmission to patients who are released before they are fully recovered is to abandon responsibility for them.

Hospital Care Is Always Harmful to Patients?

Inpatient care can harm some patients; especially harmful is long-term inpatient care that undermines the patient's ability for self-support. This true observation is analogous to the cardiologists' discovery that excessive bed rest is bad for most patients. It can produce

an atrophy of disuse. Cardiologists, however, have not refused bed rest to cardiac patients. Yet, many mental health policy makers actually deny, both implicitly and explicitly, the therapeutic values of even short-term hospital care. In fact, short-term hospitalization, in many instances, can actually prevent long-term institutional placements by speeding the process of resolving a crisis in the course of the disorder, and by providing relief admissions (Gruenberg, 1974b). The tendency to deteriorate in personal and social functioning is greatly reduced if the patient's fulfillment of ordinary living roles is systematically preserved. This is best facilitated by maintaining patients in their community life as much as possible. However, modern community care always places some burden on families or neighbors, who are generally willing to accept the troubles. But if the burden becomes too prolonged, or is too limiting on the lives of other household members, their attitude toward the patient is likely to become more negative. Once rejection toward the patient occurs, it is almost impossible to reverse.

State Hospital Care Is Inherently Restrictive?

State mental hospitals have too often been overly demeaning, overly restrictive, and dependency engendering. But the recognition that they can sometimes do more harm than good has developed into a belief that they can never do any good. Hence, the court decision that mental patients must be treated in the "least restrictive care" setting has been interpreted to mean that any care is less restrictive than state mental hospital care, even though these hospitals can often provide care with less restriction on the patient's life than can nursing homes, adult residency hotels, and general-hospital, locked psychiatric wards.

Community Psychiatric Services Can Provide Good Care for All Psychiatric Patients?

Even the best community mental health service cannot provide the type of long-term psychiatric attention that is most beneficial to chronic seriously mentally ill patients, even if it has a close, cooperative relation with an inpatient service (Gruenberg, 1972). There are patients who are going to be dependent on psychiatric care for many years; today, we cannot predict with confidence whether an

individual patient in crisis will restitute quickly or slowly, almost completely or only partially. And for the restituted patient, we cannot predict whether or when he will relapse. Hence, many crucial decisions must be made on a "try-and-see" basis. In such cases, those who do the "trying" ought also to be able to "see." If the person who decides to send a patient home is different from the person who sees the result, neither is able to learn from the decision that has been made for that patient. What is needed is a unified clinical team, to take responsibility for conducting aftercare and follow-up after its own decision to release. If, when these team members readmit, they themselves continue the treatment of the same patient within the inpatient service, they will not have any grounds for feeling that someone else had failed the patient, and will learn to respond realistically to what they can do for that particular patient.

In contrast to the unified community and hospital services that chronic mental patients need, the current direction of policy has been to add on more and more treatment elements and more and more treatment personnel—community general-hospital psychiatric units, mental health center outpatient units, nursing homes, half-way houses, quarter-way houses, patient advocates, patient management teams, psychologists, sociologists, and social workers. Each of these has a contribution to make, but shifting the responsibility from one clinical setting to another, and from one category of treatment personnel to another, simply adds to the selective ignorance with which each one approaches the patient's problems and increases the patient's frustration. If implemented, the recent recommendation of the President's Commission on Mental Health (1978) for a system of case managers—to provide the "human link" to "assist in assuring continuity of care and of a coordinated program of services"—would simply make it easier for the patient to cope with the fragmented services available to him. It would do nothing to reduce that fragmentation, and is certainly no substitute for the unified clinical-team approach most beneficial to chronic seriously mentally ill patients.

Reducing State Hospital Beds Saves Money?

The purpose of a community's financial investment in health work is to preserve and restore people's health. That costs money. For people who are irreversibly damaged by disorders, communities are will-

ing to purchase a certain amount of decent care as an expression of concern, and as a way of relieving the impaired person's family of carrying an excessive share of the burden imposed. Actually, the period of census decline in mental hospitals has been accompanied by increasing budgets for mental hospitals. It does not matter, for purposes of this paper, why this has been so. What matters is that reducing the number of mental hospital beds does not always reduce the size of mental hospital budgets. When mental health policy makers compete with budget directors to hold down governmental costs, we get patient abandonment, not cost savings.

Recommendations

In order to move out of the present chaotic situation and away from the tendency to abandon large numbers of seriously mentally ill people to community neglect and deprivation of clinical services, it is necessary to reappraise in a fundamental way the role of mental hospitals within the network of treatment services available for the mentally disordered population. A moment's reflection makes it clear that twenty-five years ago, in 1954, one could not have anticipated the current crisis in mental health services on the basis of a rational extrapolation from the past. There is even less reason to think that one can anticipate now what the problems of delivering mental health services will be twenty-five years hence. Technological innovations, fundamental discoveries, and new ways of relating to people with mental impairments in a constructive fashion are bound to occur. Community structures and personal life styles are in a state of flux. Therefore the immediate problem is to set a new direction of development, not to plan for the indefinite future.

Since the debates concerning the CMHC legislation described by Brown in 1964, there has been a systematic effort to phase out mental hospitals, which have been struggling to survive under a cloud of imminent demise. In fact, there are many thousands of people today in the care of state mental hospitals for whom no immediate alternative is available. Many of them have no families who are concerned with them. Many live in areas where there is no mental health center and no immediate prospect of one's being created. No appropriate group houses are available for many of the patients. Therefore it is unreasonable to think that a policy of phasing out

mental hospitals will work in the immediate future. To push seriously impaired patients out of hospitals into unsafe living arrangements is to abandon them. On the other hand, the mental hospitals have plants and staffs accustomed to providing care for the most difficult types of chronic mental patients. But their sole potentiality for providing constructive care, including community care for their own patients, is frustrated by numerous problems and constraints (Talbott, 1978) in addition to the fragmentation of state and local responsibilities for these patients. The programs tend to be dominated by the latest available federal pocket of money rather than by any coherent plan for moving the hospitals into the most useful pattern of functioning.

The time has come for a fundamental reappraisal of the various ways to organize mental health services, which will make the most constructive use of each. The primary focus of attention must be on that group of chronic mental patients who benefit least from the existing fragmented pattern of services. For these people, it is necessary to have unified clinical and social service teams that can take ongoing responsibility for them, both when they are living in the hospital and when they are living in the community, and can become familiar with the social and clinical resources that can be used to help them function.

It might be thought that this reappraisal should be made within the United States frame of reference. But the peculiarities of this frame of reference are its fifty states, its National Institute of Mental Health, its heterogeneous forms of local government in fiscal crisis, its affluence and very high density of psychiatrists and other mental health workers relative to the rest of the world, its peculiarly chaotic system of medical care in general, and its proclivity toward organizing medical care that emphasizes acute treatment episodes in particular. These are extreme forms of variations that exist elsewhere; the principles of psychiatric treatment and the armamentarium of psychiatric treatments do not vary from country to country, even though the density of services may vary a great deal. It is therefore not sensible to think that the needed reappraisal will emerge solely from an examination of the current crisis in the American mental hospital scene. We do not recommend a particular form of institution to carry out this reappraisal and to monitor its implementation over the next decade or two. It seems clear that existing government agencies and voluntary associations have already come to represent

vested interests, just as professional associations do. Clearly, neither the joint commission nor the presidential commission type of structure is capable of coming to grips with these issues. How a new kind of entity can develop an independent perspective, making constructive use of all of the knowledge, techniques, and service resources now available to us, we leave to someone else's more fertile imagination.

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