

## *Deciphering Deinstitutionalization: Complexities in Policy and Program Analysis*

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**S**OCIAL POLICY and reform-oriented social programs of the last fifteen years seem to require continuous decoding and re-examination. Not only has there been a substantial gap between promise and general outcome (Warren, Rose, and Bergunder, 1974), but also the rhetoric of progressive reform has frequently created expectations of social change that have not been met; often the results amount to betrayals of the intended beneficiaries, if not of the policy makers themselves (Rose, 1972). Indeed, the most common pattern in the American experience of social reform since the Kennedy years has been one of liberal optimism, political mobilization behind loosely conceived programs, demonstration projects, more generalized funding, and then a quiet slide into criticism and cynicism. The Juvenile Delinquency, Community Action, and Model Cities programs, among others, were begun in an atmosphere of conflict; the programs then declined, while endless battles occurred within localities as agencies fought to maintain their control over previously negotiated domains, and eventually became absorbed into the federal bureaucracy.

The fate of deinstitutionalization policies, however, has differed somewhat from that of other contemporary programs. Some cor-

respondence has existed between promise and performance. These programs began with all the rhetorical force of initiatives in other policy areas, and at about the same time, but not all of them have been dismantled. Deinstitutionalization policies, although they have met increasing criticism that ranges from skeptical to hostile in tone, have held their own in varying degrees. Two clear-cut questions remain: What relation exists among deinstitutionalization theory, policy, and practice? And why has this policy survived and grown while other broad-scale social reforms are declining or dead?

Deinstitutionalization on a large scale has been attempted in four areas of public social policy: in juvenile delinquency, adult criminal justice (where efforts to prevent institutionalization through "diversion" programs have received more attention than early release efforts),<sup>1</sup> mental retardation, and mental health. The last areas, mental illness and mental health, have become the broadest, with policies and programs at the federal, state, and local levels. They are also the most controversial and may be the most complex to decipher, since data are available to prove almost every contention about the programs.

Deinstitutionalization is a major departure from previous psychiatric practice. In fact, institutions such as state hospitals, state schools for the retarded, reformatories for juvenile offenders, and prisons have been the mainstay of policy and treatment practice since Dorothea Dix's campaigns in the first third of the nineteenth century (Rothman, 1971). Before 1955, various forms of segregative institutions were the preferred mode of treatment for people suffering from the very serious forms of mental disability, as well as for delinquents and adult offenders. Achieving their construction was as significant a reform as closing them down now appears to be.

## Defining a New Policy

Most simply, deinstitutionalization is a formal policy of the federal government, first articulated as a direction for public policy in 1960 and 1961 and then proclaimed as a political goal by President John

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<sup>1</sup>Scull (1977), however, cites a study called *The Quiet Revolution*, by Robert Smith, which indicates large-scale discharge of delinquents.

F. Kennedy in 1963. The Joint Commission on Mental Illness and Health's *Action for Mental Health* (1961) asserted that psychiatric patients were not being helped by their incarceration; in fact, it argued that long-term stays in hospitals were debilitating, producing institutionalized behavior and a tendency toward chronic illness; hospitals were extremely costly and therapeutically little more than large-scale custodial warehouses. The commission recommended that all efforts be directed toward preventing hospitalization, curtailing its length when it was unavoidable, and returning patients to community life, where ideally they would be rehabilitated through community-based services. Services funded through the community mental health centers (CMHC) program were to be delivered through locally based, comprehensive, mental health service centers; these facilities would be designed to prevent mental illness, to catch problems early before they became serious, and to prevent existing problems from becoming chronic by providing aftercare. At the same time, the states would save at least part of the cost of operating large custodial institutions, which would be phased out and replaced by smaller local facilities; the federal government would also help finance local programs planned through state and local agencies.

The program received rapid bipartisan political support since it represented both a progressive social reform and a tremendous saving.

The numerical results of deinstitutionalization to date are evident in a rapid decline in the inpatient populations of state and county hospitals, amounting to a reduction of over 62 percent nationally from 1955 to 1974 (Comptroller General, 1977). Projected savings to the states from this practice are discussed below, but evidence of benefits to psychiatric patients, especially those hospitalized over long periods, is not to be found anywhere in the professional literature. Conversely, those who have reported on the programs, from the office of the comptroller general of the United States to numerous special commissions and investigators (in New York, for instance, the Moreland Commission and the special prosecutor's office), have exposed fraud and abuse and exploitation of former patients (see Hynes, 1977; Comptroller General, 1977; New York State Assembly, Joint Committee, 1975).

This article will attempt an analysis of deinstitutionalization policy and will focus on the sector of community mental health care, its approach to reform, its programs and practice, its ac-

accomplishments and difficulties, and criticisms of its operations or results. My aim will be to raise questions about the actual function and efficacy of deinstitutionalization as a strategy of social reform.

## Problems in Evaluation

Among the more difficult tasks in evaluating deinstitutionalization is determining who benefits from its status as a reform policy. Both the ideology of the community mental health movement and the stated intentions of the programs define the mentally disabled as the primary beneficiaries, although policy statements do mention the need to reduce costs to state governments. Some data indicate, however, that large groups of former patients have not benefited at all and may even have been harmed by the policy. The rising recidivism rates, along with rising rates of new admissions, indicate that deinstitutionalization has failed substantially in preventing mental breakdown or hospitalization, while at the same time tremendous progress has been made in reducing the overall number of inpatient beds in state hospitals. How can we account for the remarkable success in achieving the latter goal and the devastating defeat in moving toward the former? Moreover, what criteria can be used to assess these matters, or from what perspective can we select the proper data or the proper approach to evaluation?

These problems, difficult in their own right, become even more so when we examine the issue of "legitimation" (or traditional social approval). For a century, mental disability or dysfunction has been considered a medical problem; recently the influence of the psychiatric viewpoint has precluded almost any other form of thought about mental dysfunction. People in severe mental or emotional distress are called "sick," are placed in hospitals, and are "treated" by health care teams, usually headed by a physician, which rely on medication as a primary form of therapy. Other typical therapeutic modalities within the state hospital system also focus on defects in the individual as an explanation for mental disability, yielding what are intrapsychic or intrapersonal responses. This point of view prevails beyond treatment rooms and hospitals to the apparatus for program planning and defining policy as well. The shift from custodial care to community-based care amounts more to a substan-

tial relocation of existing treatment practices than to a redefinition of the nature of the problems and a subsequent redetermination of needs and programmatic responses. Factors critical to daily social existence—such as supportive and healthful housing environments, sufficient income to sustain life and promote rehabilitation, and support services from within the community—were at first ignored as deinstitutionalization was put into practice. This form of neglect cannot be imputed to either simple ignorance or intent; instead, it must be understood as flowing from a psychiatric predisposition to focus on the medical and psychiatric needs of hospitalized and former patients, as if subjective existence were social life itself.

## Historical Background

Surprisingly, major disagreement has arisen over the question of when policies resulting in the discharge of large numbers of patients began, and what role was played by the advent of psychotropic drugs in bringing about the general policy that began to be articulated on a national scale in 1961. Mental health care in state hospitals had changed little from the turn of the century until the period immediately following the Second World War, when the impetus for change came from outside the mental health professions:

Military leaders were astonished to find almost two million draftees rejected from the services for mental disorders or deficiency; the admirals and generals had had no idea that there were so many mentally unreliable persons. Even though rejection rates before training significantly restricted the supply of able-bodied servicemen, the military accepted the psychiatrists' judgments in these cases and thus enabled psychiatry to expand its role and authority in the medical services. (Musto, 1975: 58–59)

A series of steps that included the creation of special hospitals for veterans and the development of a new mental health unit, later the National Institute of Mental Health (NIMH), marked the beginning of the first major federal-level involvement in mental health policy, an area previously a part of the domain of the states.

National involvement increased rapidly after the Joint Commission on Mental Illness and Health published a research report that

was the culmination of five years of work, begun in 1955. *Action for Mental Health* set forth the basic goals of what were later to become national theory, policy, and practice standards for community mental health care:

The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all service to mental patients. (Joint Commission, 1961: xvii)

The major focus of public reform in mental health officially became the state psychiatric hospital, which was proclaimed the source of the problem and was slated for immediate cutbacks and eventual elimination. In fact, the state hospital system had already begun to decline by 1961; Scull (1977) has shown that inpatient populations of state and county hospitals reached their peak of 558,000 in 1955. By 1963, when the CMHC program was articulated in President Kennedy's now famous "bold new approach" speech, the population had reached 504,600 (Scull, 1977: 67; Comptroller General, 1977: 8); it has been declining ever since.

### Reasons for the Policy of Deinstitutionalization

Just as important as when deinstitutionalization began is why it commenced when it did. Those who strongly supported community mental health care saw it as a humanitarian reform designed to improve mental health services and help prevent both mental illness and institutionalization. They decried traditional psychiatry and its custodial practices, or "warehousing," and considered the new approach to be a "revolution" in the field. Bellak (1964) is only one example of those who supported this view. Bassuk and Gerson believe that the role of the new drugs complemented external political pressures toward deinstitutionalization: "The pressure was further augmented by the desire of state legislatures to reduce the financial burden of state mental hospitals" (Bassuk and Gerson, 1978: 47).

Others think that the motivation for altering institutional psychiatry was entirely economic, that the asylums had indeed become warehouses with little noticeable effectiveness and monumental cost. The proponents of this view also comment on the growing admission rates at state hospitals, which increased 52 percent between 1955 and 1972, while some point out the looming inevitability of large-scale capital construction costs for new institutions to house the growing numbers of inpatients (Musto, 1975; Scull, 1976, 1977). Reduction of the inpatient population became an economic necessity. Reich and Siegal (1973: 38–39) describe the situation in this way:

Due to years of starvation financing, the state hospitals by and large were unable to provide their patients with currently acceptable or adequate standards of psychiatric care . . . .

The states, under court pressure to upgrade facilities, faced a dilemma. The cost of overhauling buildings and providing programs for institutions which had been underfinanced for 50 years would be immense. At a time when state budgets were tightly squeezed and increased taxation was politically unpalatable, the millions of dollars necessary for improved psychiatric services to the chronically mentally ill and retarded were simply unavailable. Another means of caring for chronically mentally dysfunctional patients would have to be found.

Whether the change resulted from a humane new concept of mental health care or from more crude fiscal motives, the problem of understanding why deinstitutionalization was undertaken is further complicated by the equally polarized views expressed in the literature about the role of psychotropic drugs. The Joint Commission, dominated by the medical profession, cites the positive position: “Drugs have revolutionized the management of psychotic patients in American mental hospitals, and probably deserve primary credit for reversal of the upward spiral of the State hospital inpatient load” (Joint Commission, 1961: 39). Bellak (1964) takes a middle-of-the-road position, arguing that such drugs made community mental health care a practical policy. Scull (1976) and Mechanic (1969) take the more critical view; both say that the medication argument is simplistic, reinforces the medical view of insanity as illness, and “is empirically inaccurate and inadequate in other ways as well” (Scull, 1976: 178) as a rationale for deinstitutionalization.

Historical irony adds to the confusion. The first major change in mental health practice, which some refer to as the first psychiatric revolution, was the establishment of the mental hospital or asylum. After many years of legal and legislative battles, twenty-eight of the thirty-three states established state mental hospitals during the first half of the nineteenth century. The Jacksonian period brought with it an air of uncritical optimism that took over the field of mental health as well as most other areas of society. In the newly emerging asylums, the medical superintendents were projecting 100 percent cure rates (Arnhoff, 1975: 1278). According to Bassuk and Gerson (1978: 47), "by 1900 more than 100 new state institutions were built." Rothman (1971: 110) describes their orientation to mental illness as complex, if not contradictory. On the one hand, "every general practitioner in the pre-Civil War era agreed that insanity was a disease of the brain," while, on the other,

medical superintendents' explorations of the origins of insanity took them into practically every aspect of antebellum society, from economic organization to political and religious practices, from family habits to patterns of thought and education. And little of what they saw pleased them . . . . Everywhere they looked, they found chaos and disorder, a lack of fixity and stability. The community's inherited traditions and procedures were dissolving, leaving incredible stresses and strains. (Rothman, 1971: 114)

After more than a hundred years we have come full circle, and the new revolution in psychiatry is necessary to deal with the problems posed by the old one. Physicians still believe that insanity is a disease either of the brain or in it, but the focus of problem analysis in the new era is also on the environment, if only on the environment of the asylum (Goffman, 1961). Essentially, the medical view of mental illness has gone unchanged, and the transformation that did take place was one of type rather than kind—one in which the same basic types of service would be delivered through a new community-based delivery system. Put another way, the nature of the change was to move predominantly old, medically defined, inpatient services to new outpatient facilities. The hospital came under attack as if it somehow existed independently of the profession that managed it, proclaimed its virtues, and supervised its decline, while



always rationalizing its existence—a process that allowed for continued medical control. A further irony, which Bassuk and Gerson (1978: 47) note, is that the initial development of the new state hospitals was economically motivated; they were seen as a cost-effective treatment setting that was preferable to smaller but more numerous county institutions.

## Community Mental Health Centers: Policy and the Program

At the center of the new federal master plan for preventing mental illness, preventing chronicity, and restoring long-term patients to community life was the comprehensive community mental health center (CMHC). Mobilization of political support for this service delivery system was tremendous, since the program had received some earlier stimulus from innovators within the mental health system (Milbank Memorial Fund, 1959).

The CMHCs were charged in the first legislation with providing five essential services (inpatient, outpatient, partial hospitalization, emergency services, and consultation and education). They were to provide aftercare services for those released from institutions, provide alternative short-term inpatient service for those who had to be hospitalized, and reduce the need for hospitalization by providing emergency services to people in crisis. The CMHCs were the heart of a federal program of grants to support the construction of facilities and, later, for staffing.

Each CMHC was designed to serve a gerrymandered geographic area or catchment with a population of 75,000 to 200,000 people. (For a critical discussion of the neglect to define the key term “catchment” adequately, see Panzetta, 1971.) The National Institute of Mental Health estimated in 1963 that it would take approximately 1500 such centers to serve the entire population of the United States. The rate at which they were established has been slowed somewhat over the years, but “as of July, 1975, NIMH had awarded construction and/or staffing grants of \$1.2 billion to 603 CMHC’s. When all 603 CMHC’s become operational, they will serve areas covering about 41 percent of the U.S. population. As of July, 1975, 507 CMHC’s were in operation” (Comptroller General, 1977: 68).

### *Problems with the CMHC Program*

Although the fact received little attention from the media or from policymakers during the first ten years of the community mental health center movement, most activity inspired by community mental health care and brought about by federal policy was at the level of the state, where deinstitutionalization proceeded rapidly after 1963. The data from the comptroller general's five-state study (Table 1) show that the inpatient population declined by 38 to 84 percent. Data from the state of New York, where the number of patients decreased from over 90,000 in 1955 to 39,223 in 1974, confirm this picture (Lander, 1975: 19). Bassuk and Gerson's (1978: 49) data from 1955 to 1975 are also consistent with these estimates: "There was a 65 percent decrease in the census of resident patients in state mental hospitals, from 559,000 to 193,000."

TABLE 1  
Decline in Mentally Ill Inpatient Population, 1963-1974

| State         | Population |        | Reduction |         |
|---------------|------------|--------|-----------|---------|
|               | 1963       | 1974   | Number    | Percent |
| Maryland      | 8,100      | 5,000  | 3,100     | 38      |
| Massachusetts | 17,500     | 6,000  | 11,500    | 66      |
| Michigan      | 20,100     | 6,000  | 14,100    | 70      |
| Nebraska      | 3,700      | 600    | 3,100     | 84      |
| Oregon        | 4,060      | 1,260  | 2,800     | 69      |
| Total         | 53,460     | 18,860 | 34,600    | 65      |

Source: Comptroller General, 1977: 9.

The same pattern appears to have continued from 1963 to the present. As CMHCs were expanding in size and number, state hospitals were housing fewer and fewer inpatients and, in some cases, even being phased out of existence (Chase, 1973). According to public testimony by NIMH officials, a decrease in state hospital populations and the phasing out of these institutions were a main goal of the CMHC program and its primary justification (Chu, 1974: 777). From the beginning, the CMHC movement was portrayed as a means of reducing state hospital populations by 50 percent within ten years. Sources as widely disparate as, on the one

hand, NIMH and the comptroller general's office, and, on the other, the Nader group and Scull, present similar evidence. Its implication is clear: thus far, in relation to its primary goal and its essential rationale, the CMHC program has failed.

A team of NIMH researchers reported in 1973 that they could not establish a clear and consistent relation between CMHC development and change in the inpatient population at state psychiatric hospitals (Musto, 1975: 69). The comptroller general's report states:

NIMH data on sources of referrals to CMHCs also indicate that the CMHC program was having only a limited impact on reducing public mental hospital populations. For example, for 1974 NIMH reported that about 29,300, or about 3.8 percent of the 780,400 additions to CMHC's were referred by public mental hospitals. Public mental hospitals accounted for fewer referrals to CMHCs than any other referral source reported, except for the clergy. (Comptroller General, 1977: 69)

This same report (1977: 72) contains a further indictment of the CMHC program:

In general, the CMHC program has developed apart from the public hospital system. Many CMHCs did not view reducing the use of State mental hospitals as a primary goal and therefore did not direct much effort toward this goal. The lack of a formal link between the CMHCs and the public mental hospitals helped fragment responsibility for the mentally ill released from mental hospitals. It also appears to have hindered the accomplishment of two CMHC program goals—reducing the use of mental hospitals and providing a coordinated system of care for the mentally ill.

The Nader group report (Chu and Trotter, 1974) makes the same charges. Chu, its co-author, concluded (1974: 775)

that community mental health centers have largely failed to fulfill any of their major stated goals. They have not supplanted state hospitals; they are not usually accessible. . . . They have continued the two class (rich and poor) system of care by frequent exclusion of indigent patients as well as those with the most severe problems . . . and centers are not held accountable to NIMH, which means they continue to receive NIMH funds whether or not they are fulfilling NIMH goals.

### *Providing Aftercare*

On March 1, 1976, the New York State Assembly's Joint Committee to Study the Department of Mental Hygiene submitted *Mental Health in New York*, a comprehensive study of public mental health services; it did not even mention CMHCs as pertinent to public mental health care in the state or in programs it surveyed in four other states. The direction of the 1975 amendments to the federal CMHC legislation, providing for the development of aftercare in supportive living environments and a series of related services coordinated by the CMHCs, also failed to influence CMHC practice substantially, as the comptroller general's report indicates. How can we account for this phenomenon? How can a major mental health policy, articulated by the federal government and supported by the state governments, have no direct bearing on the bulk of publicly funded mental health care in the public sector?

This last question is a difficult, but necessary, one to pursue. What makes it difficult is the apparent failure of deinstitutionalization policies to provide even minimally adequate aftercare and community support services anywhere in the nation. Instead, the rhetoric of deinstitutionalization seems to mask a brutal political and economic reality—the general abandonment of mentally disabled people who have been further debilitated, mentally and physically, by institutionalization. Evidence indicates that the 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.” The extent to which this last provocative claim is accurate was made clear by a special prosecutor appointed by the state of New York to investigate abuse in the nursing home and adult home industries. His report severely criticized the concept of community mental health care and cited the failure of federal, state, or local officials to develop adequate community-based services for former patients: “The discharge of mental patients from psychiatric hospitals without insuring the delivery of aftercare services makes deinstitutionalization a procedure for patient aban-

donment, rather than a progressive program of patient care” (Hynes, 1977: 41).

## Organizational Coordination

Abandonment of organizational responsibility, as well as of patients, characterizes deinstitutionalization:

Deinstitutionalization has not received the full and well-coordinated support of many State and local agencies administering programs that serve or can serve the mentally disabled. Moreover, agencies serving population groups that do or could include the mentally disabled have not included deinstitutionalization of the mentally disabled in their program plans nor have they made it a specific operating objective or priority. Furthermore, they have not provided financial or other support needed to help mentally disabled persons (1) avoid unnecessary admission or readmission to public institutions, (2) leave such facilities, or (3) receive appropriate help in communities. (Comptroller General, 1977: 24)

Mental health departments have refused responsibility for housing, welfare, or medical or other social needs, while other agencies were frequently not involved in discharge planning or in the development of joint programs. In a study of nine cities that focused on interagency cooperation and coordination, made when CMHCs were growing most rapidly, Warren, Rose, and Bergunder (1974) found that community mental health agencies were the least competent or interested in initiating or responding to invitations to collaborate, while other agencies demonstrated interest only in protecting or enhancing their own domains.

The effect of the agencies’ attitudes has been disastrous for former patients and for the communities into which they have been placed in large numbers, yet no practical mechanism for assuring that agencies will carry out their responsibilities has emerged. Thompson (1975: 60) notes, “Anyone who has spent any time evaluating residential care is aware of the inadequacy of many of these facilities. Often this inadequacy is not openly discussed by mental health policy makers for fear that somehow it will be blamed on them.” Reich and Siegal (1973: 54) argue pointedly that “no adequately prepared organizations or facilities exist to handle all of the new discharges.” They conclude (1973: 55) that the policy

originally perceived as radically innovative and humane has turned into its opposite: "To discharge helpless, sick people into the street is inhumane and contributes to the decline of the quality of life in the urban environment." The overall effect of the policy prompted the *New York Times* to say that deinstitutionalization has served to transfer the back wards to the back alleys (Musto, 1975: 70).

## The Role of Drugs

As if this problem were not complex enough, the debate intensifies when we turn to the role of psychoactive and/or neuroleptic drugs. As already mentioned, substantial data indicate that the process of discharge began in 1955, after such drugs were introduced into some hospitals, but well before they came to be seen as the panacea for mental illness. Bellak (1964: 3), an ardent proponent of community mental health programs, is hesitant to call the drugs a cure-all but says that "nevertheless, they have made community psychiatry a reality." Musto (1975: 70) supports this contention, but from a more critical stance: "The hospital census has been reduced by means ranging from hospitals' abundant use of drugs to the massive discharge of patients, many of them elderly, to proprietary nursing and foster homes." Perhaps the most powerful indictment comes from within the ranks of psychiatry, in a paper by Crane (1973: 124):

In the last decade, hospital beds have been increasingly phased out; and, to take their place, new community mental health centers have been opened or existing facilities have been expanded throughout the nation. According to the medical profession, this new program for the treatment of the mentally ill would not have been possible without neuroleptics. . . . Inadequate programs for the management of these mentally handicapped persons have created new and unexpected problems, and, in an effort to solve them, the psychiatric community has become more and more dependent on the use of neuroleptic agents. One of the consequences of this reliance on psychopharmacology has been the tendency to minimize the potential danger of long-term exposure to powerful chemical agents. Thus, permanent neurological disorders have become very common among patients treated with neuroleptics, but little effort has been made to come to grips with this problem.

Bockoven and Solomon designed a study to compare two groups of patients discharged from psychiatric hospitals, one before the current levels of drug use and one after. The study was based on two five-year follow-up evaluations, the first between 1947 and 1952, and the second between 1967 and 1972. They found no substantial difference between the two groups, an unexpected result "in view of the absence of psychotropic drugs during the entire five years [of the first study], compared with extensive use of psychotropic drugs . . . for both initial treatment on admission and the entire period of after-care" (Bockoven and Solomon, 1975: 800). The failure of community mental health agencies to develop adequate or appropriate aftercare programs is linked by these authors (1975: 801) to overfixation on drugs: "The presence of adequate rehabilitation and social maintenance programs would decrease the tendency to rely on psychotropic drugs as the mainstay of aftercare."

In the eyes of these and other critics, drug dependence is more a problem of the profession prescribing them than of the population seduced or coerced into taking them. According to Crane (1973: 125), "drugs are prescribed to solve all types of management problems, and failure to achieve the desired results causes an escalation of dosage, changes of drugs and polypharmacy." Neuroleptics are used to control behavior or to facilitate management, and to solve psychological, social, administrative, and other difficulties that are nonmedical in nature. Scull (1976: 86) calls this drug dependence "the technological fix" and argues that the research methodology used to justify the use of such drugs was shabby and unscientific. Research conducted by Tobias and MacDonald in 1974 confirms this assertion; on the basis of forty studies, they concluded "that because of methodological flaws, no inferences can be drawn" (see Scheff, 1976: 303).

The situation would be bad enough if the only problem were overzealous use of drugs by a profession that depends on them to produce manageable behavior in patients so that state hospital beds can be emptied in response to political policy. Unfortunately, the problem is deeper: long-term use of such drugs as the phenothiazines may prolong social dependency and create harmful and irreversible neurological damage. Crane (1973: 127) notes that the predominant form of this damage, usually called tardive dyskinesia, has been attributed to psychotropic drugs for at least ten years and that more than a hundred papers had been published about it by 1973, but with

little impact on the profession of psychiatry. Gardos and Cole support this view. From their review of the literature, they conclude that as many as 50 per cent of the chronic patients discharged to aftercare "may not need to be on antipsychotics, either because they would do well without medication or because they would not do well on drugs for reasons including failure to find optimum drug or dose level, non-compliance, or toxicity" (Gardos and Cole, 1976: 34). They also discuss tardive dyskinesia, and speculate that the number of people neurologically damaged by this by-product of psychotropic medicines may be larger than has previously been estimated, because the ailment can exist in a suppressed form while the drug is still being taken.

Among the other failures of drug-dependent aftercare is the refusal to acknowledge the relation among barren, empty lives created by massive discharges into hostile communities, grossly underdeveloped community support services, and increasingly high levels of rehospitalization. Recidivism rates rose nationally from 47 percent in 1969 to 54 percent by 1972 (Comptroller General, 1977: 22). In New York, the figures are even higher, reaching almost 65 percent in 1974 (Lander, 1975: 2-3), compared with 27 percent in 1955. Since admissions have doubled in the same period, the actual number of people released from hospitals is awesome. According to Bassuk and Gerson (1978: 49), "admissions to state hospitals increased from 178,000 in 1955 to a peak of 390,000 in 1972 and had declined only to 375,000 by 1974. . . . Moreover, a growing proportion of the admissions were readmissions (in 1972, 64 percent of them): about half of the released patients are readmitted within a year of discharge."

In spite of the severe problems produced by deinstitutionalization, and in spite of criticism of the quality of life available to former patients discharged without either support systems or adequate social and financial resources, the policy and practice continue. Someone must benefit from them; since evidently it is not the former patients, it seems logical to examine the costs and benefits to the states that are closing the back wards of their psychiatric hospitals.

### Economic Reality

As indicated in the early sections of this paper, a different perception of deinstitutionalization can be based on political and economic



analysis. Its proponents' essential argument is that the policy of deinstitutionalization is best understood as a political and economic measure designed primarily to sustain near-bankrupt state governments and to establish the basis for transferring funds from public services to the private sector. Before the passage of community mental health legislation and the funding of the CMHC program, mental health services were paid for almost exclusively by state tax dollars. The adherents of the political-economic view note that the rising level of admissions to state hospitals, estimated to be a 100 percent increase between 1955 and 1972 (Musto, 1975: 70), would have added to the states' already substantial fiscal burden the necessity for undertaking new capital construction. As early as 1955, they point out, state governments were able "to maneuver to obtain the cost savings it offered. Some of the largest savings immediately realizable came from the cancellation of planned new construction, and decisions to do this were widespread" (Scull, 1977: 139).

Further savings would be realized through increasing federal involvement, which stimulated discharges and attempted to encourage the shifting of funds from inpatient care to outpatient or aftercare. The 1965 Social Security amendments, for example, enacted Medicare and Medicaid programs that included coverage for skilled nursing-home care to facilitate the discharge of older people to private facilities; they supported inpatient treatment of elderly mentally ill patients in general medical hospitals and funds for outpatient psychiatric care. In addition,

the act authorized inpatient mental hospital benefits for the mentally ill. This was to encourage States to discharge the elderly who, with financial assistance and supportive services, were able to live in the community. It was intended that the Federal assistance for the institutionalized mentally ill would enable the States to shift their funds to developing alternatives to care in mental hospitals and to improve the care provided in such facilities to help persons return to communities. (Comptroller General, 1977: 207-208)

Many states did not do this. In New York, in 1974, the average part of mental health budgets allocated to aftercare was 6.5 percent; at Pilgrim State, the largest hospital, the amount was only 1.1 percent (Legislative Commission on Expenditure Review, 1975).

In 1966, the amendments to the Comprehensive Health Planning and Public Health Services Act mandated that at least 15 per-

cent of state formula grant allotments for public health services be directed toward community-based mental health services. This legislation was the forerunner to the 1967 Partnership for Health amendments, which required that at least 70 percent of public health services funds for mental health be set aside for providing services in communities (Comptroller General, 1977: 210).

### *Financial Incentives to Deinstitutionalization*

In 1972, through the Social Security amendments, the federal government further stimulated state governments to make discharge and early release their mental health policies, and intensified the growing tendency to replace state hospital wards with private skilled nursing facilities (SNF) or intermediate care facilities (ICF). This legislation "provided for financial penalties on States not implementing effective programs for controlling unnecessary use of mental hospitals, skilled nursing facilities, and ICFs, including institutions for the retarded" (Comptroller General, 1977: 213). The Supplemental Security Income (SSI) program was also authorized under the 1972 amendments but did not begin as a standard program of federal assistance until 1974. It provided the funding for cost-of-living payments to discharged patients at a level beyond what the Aid to Disabled program was able to do. Other legislation in 1975 (Social Security, Special Health Revenue Sharing, CMHC amendments) continued to stimulate community-based services, empty state hospitals, and transfer funds from public to private sector facilities and programs.

The states were in a position to act on humane policy promises, while reducing the overall proportion of state expenses devoted to mental health and shifting the cost of care from state to federal funds. A major saving resulted from discharging large numbers of mental patients from the state hospitals. One estimate (Comptroller General, 1977: 5) of the annual average cost of caring for a person in a public mental hospital in 1974 was \$11,250. In New York, during the same period, the cost per person was \$13,835. The cost of outpatient care in New York, or aftercare combined with outpatient care, during 1974 was \$531 per person per year of state mental health department funds. This fantastic saving was offset somewhat by the fact that a person discharged from the hospital was

necessarily referred to SSI; this meant that residents of New York who were placed in adult homes received a monthly check of \$386.70 (before October 1, 1977, when an additional \$18.00 of personal allowance money was added). The monthly cost to the state for each SSI recipient living in an adult home was \$219.00, while the federal share was \$167.70. On an annual basis, the cost to the state of New York for such a person consisted of \$2,628 of SSI funds (or less if the person was placed in a boarding home or hotel), plus \$531 of mental health funds. If an overestimate of \$1,500 is added for various services, the total still comes to just over \$4,600, some \$9,000 less than the annual per person cost of hospitalization. In New York alone there are 50,000 fewer inpatients in 1979 than there were in 1968, and more than 65,000 fewer than in 1955; the amount of state money saved thus becomes all too apparent as a motivation for complying with federal incentives to deinstitutionalize. In 1968 dollars, the amount saved would be somewhere in the vicinity of \$585 million per year, without projections of the additional costs from rising admissions figures and possible capital construction.

A number of studies of savings as a result of community-based care have been made in the past five years. Ironically, most of them do not specify that total costs, including those incurred by the federal government, have gone up, and that one major reason for overall increases involves paying for profit margins assumed by private-sector domination of the residential market for housing discharges from state hospitals, a point discussed below. The comptroller general's office reviewed a number of cost-benefit studies and discussed the findings in its report. Three factors were selected as central to reducing the cost to the public: housing, employability, and primary source of funds; for instance, the cost of community care could be greater than the cost of state hospital care when the person involved was in an intensive-care setting or a private facility, unemployable, and dependent on public funds for support. Overall, however, savings were substantial—an average net saving of \$20,800 per person, with one state showing a saving of \$39,400, both calculated over a ten-year period (Comptroller General, 1977: 5). These figures include the costs of skilled nursing and intermediate-care facilities, which lower the savings substantially when compared with the costs of adult homes or boarding home situations. In New York in 1976, a relatively small percentage of people were placed in such high-cost facilities rather than in nonmedical group residences or boarding

homes. Using the national average, however, multiplied by the number of inpatients discharged since 1965, we can see that an estimated cost savings to the *states* in the ten-year period from 1965 to 1974 would be approximately \$5.4 billion, again without regard to accelerated admissions rates and added capital construction costs.

The cost-benefit analysis cited by the comptroller general's office, which estimated that \$20,800 per person would be saved over a ten-year period, was prepared by Murphy and Datel (1976). They based their calculations on criteria for deinstitutionalization that included comprehensive and continuing care in a community setting, progress toward independent living, and improved integration of community services. They also pointed out that the client population was made up of "successful" cases of discharge: "Recidivists were dropped from the analysis, as were clients likely to be reinstitutionalized, since they represented a failure in the community services system" (Murphy and Datel, 1976: 166). They reached two conclusions: first, that "federal sources are shown to carry much of the load on maintaining deinstitutionalized clients," and, second, that "benefits accruing to state funding sources through deinstitutionalization far exceed those accruing to federal funding sources" (Murphy and Datel, 1976: 166). A third conclusion is warranted: given the stipulations, the savings are grossly understated. This finding is supported by a comparative study by Sheehan and Atkinson of the costs of services in Texas. The authors concluded: "The real beneficiaries of the present system are the state legislatures, as the cost of supporting community inpatient services and state hospital backup care for those who need it is less than the cost of providing inpatient care through the state hospital alone" (Sheehan and Atkinson, 1974: 244).

In the apparent trade-off made in federal intervention into state budgets and mental health policies, budget aid is exchanged for more centralized decision making and for control over private sector involvement. Each time the federal government became more involved in the deinstitutionalization process, states saved money in exchange for discharging patients, contracting with the private sector to use public funds, and indenturing themselves to federal control through participation in shared funding programs such as SSI, Medicare and Medicaid, and Health Revenue Sharing. In order to save dollars for other state purposes, the state budgetary process has become dependent on federal funds. What would happen to state fiscal capability if

the federal government were to withdraw from or be unable to maintain contributions to SSI, Medicaid, and other programs? Given the federal government's fiscal power over the determination of policy and programs, if required, the social control apparatus of the states has become absorbed into the larger control needs of the federal government.

### *The Private Sector Interests*

The issue of the private sector has yet to be discussed. Its interest has been to invest in mental health service provision and/or other activities, which until deinstitutionalization were publicly funded. The success of private sector interests, both large- and small-scale, can be comprehended by remembering that hundreds of thousands of people have come into and been discharged from state hospitals since 1955, and many of them have had no family or other resources to rely on for housing or other services. Nursing homes, intermediate care facilities, adult homes, old hotels, and boarding home operations became a booming economic investment. The results in hard money terms are substantial: "Data from a survey completed in April, 1974, by the National Center for Health Statistics, HEW, showed a 48 percent increase in the number of nursing home residents with mental disabilities since 1969—from 607,400 to 899,500" (Comptroller General, 1977: 11).

The extent of fraud and other forms of criminal exploitation of nursing home residents in the state of New York prompted the governor to appoint a special commission to investigate the situation, and then a special prosecutor to follow up that investigation. Whether or not the individual owners were honest in reporting charges, the growth and income of this industry are phenomenal: "According to NIMH estimates, nursing homes are the largest single place of care for the mentally ill. They represent 29.3 percent, or \$4.2 billion, of the estimated total direct care costs for the mentally ill of \$14.5 billion in 1974" (Comptroller General, 1977: 11). To claim any value for deinstitutionalization, in light of the proportion of people placed in nursing homes, is even more ludicrous when we realize that far more than 50 percent of the nursing homes are larger in size than the back wards of the state hospitals from which the patients came; according to data collected in 1974 on nursing home residents, more than half were placed in homes with 100 or more

beds, while an additional 15 percent were placed in homes with more than 200 beds (Comptroller General, 1977: 16). Critics refer to this practice as reinstitutionalization (as opposed to recidivism or rehospitization). My argument is not against nursing homes or intermediate care facilities as such; certainly some people do need extensive medical supervision. Rather, my point is that such care is not related to the rhetoric of community living and need not be part of the profit market.

After nursing homes had been established as a successful enterprise and as a corollary of deinstitutionalization, the numbers of patients being discharged did not diminish: different types of facilities emerged to house them, with lowered levels of care provided and smaller SSI payments allocated. Given lower profit margins, the market factor required that larger numbers of people be placed. The results, particularly for former patients and "oversaturated" communities, have become commonplace. Reich and Siegal (1973: 46) describe the situation in New York:

Several private entrepreneurs saw in the policies of the State Department of Mental Hygiene an opportunity for financial gain. Under the facade of community service they refurbished unsuccessful old hotels and motels and arranged with the state hospitals to accept any patients the hospitals wished to discharge. The result is that many of these proprietary homes have become unsupervised state hospitals. Many of the patients were on high doses of tranquilizers, causing them to be apathetic, disinterested, and unable to function at any level. Young mental hospital dischargees became isolated in the homes because they were unable to relate to the average age of the other residents (over 65). Patients gathered in the lobby, gazing blankly into space, rocking back and forth, staring at a television set which had been turned off. If the clients deteriorated in proprietary homes, they were often turned out on the street when the state hospitals did not re-admit them.

In the four years after that was written, the situation continued to deteriorate, prompting the *Village Voice* on October 31, 1977, to run the headline, "State Abandons Mentally Ill to City Street."

The Nader group reported similar findings: "Mounting evidence from around the country indicates that large numbers of patients are being transferred en masse to nursing or so-called foster homes or welfare hotels, where conditions are frequently worse than those in state hospitals" (Chu, 1974: 777). Rather than rely on discharge numbers as an indication of progressive development, Lamb

and Goertzel (1971: 29) asked in a follow-up study, "To what extent have [former patients] shed their mental patient role and identity?" Investigating the typical placement in California boarding homes, they concluded:

These facilities are in most respects like long-term state hospital wards isolated from the community. One is overcome by the depressing atmosphere, not because of the physical appearance of the boarding home, but because of the passivity, isolation and inactivity of the residents. . . . Thus, boarding homes are for the most part structured so that they maximize the state-hospital-like atmosphere. The boarding home operator usually needs or wants a group of quiet, docile, "good" patients. The monetary reward system of the boarding home encourages this, for the operator is being paid by the head, rather than being rewarded for rehabilitation efforts. (Lamb and Goertzel, 1971: 31)

Chase (1973) discovered one chain of board and care homes that had thirty-eight facilities in California alone, twenty-five elsewhere, twelve general hospitals, and other holdings yielding a net revenue in 1972 of \$79.5 million. In the context of profit, and of the mental health or public welfare agencies' refusal to take responsibility for following up, inspecting, and raising charges against exploitative landlords, or for providing services, most former patients have been left to survive on their own, whether in a single room in a former resort hotel, in a nursing home or intermediate care facility, or in a boarding home. The bleak nature of their everyday lives constitutes what Klerman (1974: 786) has called a trend toward community chronicity, or marginal social existence and psychological disability maintained in a community residence, but apart from other people.

The abuse, leading to state investigations and federal congressional hearings, has become so widespread that it has paralleled the general medical abuse of Medicaid and Medicare programs, but without many of the useful services they delivered. In surveying the extent of transfers from state hospitals to private nursing and adult homes, Scull (1977: 150) concluded:

One indirect consequence of decarceration has been a much greater involvement of the private sector in spheres of social control which were formerly the exclusive province of the state. The pattern of socialization of loss and the privatization of profit, already well established in the military-industrial complex, is now imprinting itself on new areas of social existence. Particularly in America, an effort is under way to

transform “social junk” into a commodity from which various “professionals” and entrepreneurs can extract a profit. Medicare and the nursing home racket are merely the largest and most blatant examples of this practice.

## Conclusions

### *The Medical Paradigm*

In *The Structure of Scientific Revolutions*, Thomas Kuhn (1970) discusses the notion of a “paradigm,” which he defines as a set of theoretical assumptions that arise to explain enigmatic phenomena and, if they fit the needs and interests in a field, gradually become accepted as reality itself. Put another way, once room is made within the social structure and ideological framework in a given area, the new paradigm emerges to redefine that field. Once it is accepted, the underlying structure of assumptions begins to recede from conscious concern into the background, where it retains its explanatory potency but is increasingly submerged as what has now become “normal” thought and practice. Changes that develop over time turn out, in fact, to be marginal, methodological, or incremental, and uniformly within the paradigm-receded-from-consciousness. Even evaluations of theory and methodology remain bound by the paradigm, capable of assessing only the efficiency rather than the nature of a given practice.

In the social development of a field, the paradigm expands in this way until it confronts an irreconcilable internal or external problem; either scientific “anomalies” or unanswerable questions arise, or the social utility of the paradigm is called into question. In either case, but particularly in the latter, either a significant qualitative change will occur (what Kuhn considers a “scientific revolution”), or the reigning paradigm will successfully, yet temporarily, co-opt or incorporate the threat. According to Berger and Luckmann’s (1967: 24) description of this effort, “Even the unproblematic sector of everyday reality is so only until further notice, that is, until its continuity is interrupted by the appearance of a problem. When this happens, the reality of everyday life seeks to integrate the problematic sector into what is already unproblematic.” Perhaps it will be useful to briefly examine deinstitutionalization in this context.



At the level of overarching paradigms or large-scale assumption structures related to the person in our society, the theme of individualism is important; it is an accounting of an individual's well-being—or lack of it—based on the interrelated conception of the person's motivation, behavior, and psychological make-up. *In Mental Illness and the Economy*, Brenner (1973: 245) puts it this way:

The general cultural theme of individualism has had a pervasive impact on our understanding of both mental hospitalization and economic success and failure. Traditionally, it has been taken for granted that, since the mentally hospitalized patient is psychiatrically ill, mental hospitalization could be explained in accordance with prevailing theories of mental illness. These theories assumed that mental illness could be described within two broad categories, functional and organic. . . . In both of these models, the broad social environment was largely ignored.

Brenner points out the parallels in “common-sense” knowledge about individual behavior (health versus sickness) and economic position (success versus failure), identifying as a common thread disregard of the historical development of the social and economic order.

What is implied in this assumption is that, since individuals are internally accountable or responsible for their behavior, within the prevailing paradigm, responses to social or economic behavior are typically also based on premises about the individual, or about aggregates of individuals presumed to be similar by virtue of their social behavior or economic position. Furthermore, economic stability (or lack of it) or economic policy is unrelated to individual emotional or psychological condition. In the case of mental illness, the causal relations assumed to exist are only between observed behaviors classified as symptoms and the disease categories that have been created as aggregates of or receptacles for those same symptoms.

In the field of mental health, the reigning paradigm has incorporated the individualist theme from the broader ideology and historically redesignated it in medical and/or psychological terms, having appropriated the territory from an earlier individualistic definition of demonic possession. Whether the individual defect in the person has been considered organic or psychological, the dominant medical perspective has continuously claimed it as within the

province of medical control, and designed for it various organic or psychotherapeutic methods of treatment aimed primarily at the person or, at best, his or her family environment. As mentioned earlier, medical determination of the best methods of treatment has consistently been regulated by the economic needs of the state; this relationship began with the founding of the state asylums and continued through their expansion into unwieldy and costly custodial warehouses to their present dismantling. At the same time, both the medical establishment and the state government have claimed that the economic basis for change was in fact a response to a therapeutic innovation that gave rise to the organizational rearrangements that followed.

The historical development of community mental health care follows this pattern almost exactly. The state hospitals, claimed by some to be the results of the first psychiatric revolution, were established at a time of rising medical influence, which was superseded by the emergence of the states as entities economically more viable than localities. The nineteenth century saw the asylum movement and its initial premise of "moral treatment" give way to custodial care and the preliminary notions of maintenance therapy. Around the turn of the century, when moral treatment was believed medically bankrupt but the asylums and hospitals were considered socially useful, organic and functional descriptions of psychoses emerged as paramount. This change in approach is tantamount to incorporating a problem posed within a paradigm into an acceptable degree of advancement of practice. The development of the psychoanalytic tradition, still grounded in the paradigm of individual defectiveness, created a brief period of internecine or intramural struggle, still bounded by medical domination. Throughout the twentieth century, we have seen the demise of all hope for mental hospitals as curative or restorative institutions, but we are far from universally understanding why they have been substantially diminished.

From within the prevailing medical paradigm of mental health, not surprisingly, the rationale for reducing inpatient populations and creating a community mental health policy is treated as a therapeutic innovation. According to this outlook, the internal problems posed by the acceptance of institutionalization as the preferred therapeutic tool for severe mental illness led to the development of a new model. The organizational rearrangements

that ensued, in other words, came about because of a humanitarian thrust from within. Community mental health care was a “natural development,” so to speak, of the continuous search for better methods of treatment, another example of internal readjustment, this time to an externally imposed challenge to the utility of the paradigm. Aiding this process of internal adaptation was the factor of general social legitimation; that is, medical control over mental health problems had gained social acceptance, or acquiescence, even if its current practices were being scrutinized and threatened from political and economic standpoints.

Those bound by this confined orientation toward social and economic reality eagerly point to the more than 50 percent reduction in inpatient populations of state hospitals within one decade as a victory. What they cannot account for so successfully is the utter failure to accomplish the other goals: primary prevention (that is, the prevention of mental illness), the prevention of hospitalization, or the prevention of rehospitalization. What they cannot comprehend is their own social-historical nature and that of their location within the same social context as their patients. They therefore cannot perceive that economic necessity, which Brenner and others have shown to be correlated with mental hospitalization rates, has been as directly correlated to the demise of the state hospital system as it has been to the incidence of mental disablement or dysfunctioning. They also find it difficult to see that the present organizational rearrangements—the decline of the hospital system and the related rise of the CMHCs—were precipitated by economic and political factors, rather than the reverse: in this view, the mental health professions see themselves as the tail wagging the dog.

The policy of deinstitutionalization demonstrates the power of reigning and socially stabilizing paradigms; organizational rearrangements are made in the name of humane social change, while, simultaneously, traditional orientations and practices are maintained in new settings. The lives of the intended beneficiaries of the change continue to be interpreted in medical terms, but only until problems can no longer be avoided. The contemporary problem, which creates all the criticism of community mental health care, is the twofold failure of the CMHCs: to prevent new hospital admissions and to sustain discharged patients in the community. These two factors, like the problems posed by institutionalization, have relevance both internal and external to the mental health

professions. Internal problems are posed by recidivism and the failure of the CMHCs to deal adequately with state hospital discharges, while the failure of the new methods to control costs brought about by new admissions and recidivism, coupled with inflation, is external. The situation of economic necessity giving rise to political intervention remains as unseen now as it was in 1961, the last time a presidential commission reported its findings.

We will soon enter another new era in the field of mental health, one that will be presented with some of the same enthusiasm and rhetoric as the last. The "new" new era, already on the horizon with offices in NIMH and small-scale projects in a limited number of states, is that of Community Support Systems (CSS) programs. This new development is obviously an effort to recognize the failures of the old new era to anticipate and plan for concrete problems of daily life among those pushed out of hospitals into deprived and exploitative living environments. Utilizing the comptroller general's criticism of community mental health care, the new program has moved forward with tremendous energy to induce the federal government and the states to consolidate and increase efforts among various agencies, which have passed the buck from one to another in excusing failures to meet either therapeutic or economic expectations. The outcome of CSS programs, of course, cannot be predicted with great accuracy. We can speculate, however, that these programs, too, will fail to fulfill their stated objectives, to the extent that they are delegated to agencies restricted by the prevailing paradigm. Since that is at least the most likely outcome, the problems will remain. Much, if not most, of the energy of CSS program implementation will be devoted to what Kuhn called "mopping up operations," such as "demonstrating" extensive pathologies within individuals that prevent them from taking advantage of newly available service opportunities.

## Deinstitutionalization as a Broader Issue

The analytic tasks required to comprehend deinstitutionalization become even more complex when we include the areas of mental retardation, delinquency, and adult corrections. Substantial diversity exists; in some cases, much more nonprofit housing and consumer involvement is present (as in the area of retardation), or diversion

programs have become formalized as parts of the policy and program structure. How can we account for the varied patterns of utility and effectiveness of the same general policy with different groups of target populations? What has the experience been with juvenile delinquency and adult criminals? Perhaps most important, after analyzing deinstitutionalization as a social reform, how can we organize a system of reparations for those already considered its beneficiaries?

The questions raised here require a multidisciplinary, multifield investigation, one that compares the historical development of deinstitutionalization across the four policy and program fields, and focuses on the role of federal, state, and local governments, on rhetoric, policy development, and interorganizational relations, and on fiscal incentives. At the same time, it will also have to assess the role of the private sector and the voluntary agencies.

Finally, the role played by the courts must be examined. Although since 1972 they have systematically ruled in favor of deinstitutionalization for mentally ill and mentally retarded people, they have done so on the basis of material that asserted that community placement was, *by definition*, preferable to state hospital incarceration. Now that we know that such a conclusion is at best premature, and often incorrect, the role of the courts may change. Certainly that possibility was raised by the decision in a 1975 class action suit, *Dixon v. Weinberger*, in which a United States district court judge ordered a local government to finance the establishment of alternative facilities to the hospital and "accept responsibility for creating and paying for such community resources" (*Hospital and Community Psychiatry*, 1976: 205).

As Lottman (1976) points out, however, even progressive court victories stipulating efforts to design and provide adequate services have failed to yield the projected benefits because of their inability to define and implement adequate procedures to ensure compliance. Some of the recent court battles also indicate a hesitation or reluctance to challenge the psychiatric paradigm, whether traditional or contemporary. For example, court orders to place patients in the least restrictive alternative settings have been argued without adequate assessment of the quality of life in available community placements, while right-to-treatment cases serve to coerce states to put more money into conventional, psychiatrically defined, treatment modalities within state hospitals. The use of the courts, in other

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words, can either support or contest prevailing practices, depending on how aware plaintiffs and their lawyers are of the social context within which civil liberties cases are argued. As with existing policy and programs, even the evaluation of the role of the courts will ultimately depend on the conceptual paradigms used to construct the analysis.

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