

Deinstitutionalization in Context

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WHEN SO MUCH HAS BEEN WRITTEN about the process that has been called “deinstitutionalization” in the United States, and “running down [i.e., decreasing the size of] the mental hospital” in Britain, what more remains to be said? Many commentators have analyzed the process by which, in the space of less than twenty years, mental hospitals in the States have been reduced in patient population by about two-thirds, and those in Britain by about one-third. On both sides of the Atlantic, there has been much talk of community-based services, and some disappointment at the slow process of development. We have studied some remarkably unyielding statistics, and only guessed at the volume of human misery that lies behind them. We have had moments of vision, in which there really seemed to be new possibilities for helping the mentally ill, and longer periods of despair, in which the new dispensations seemed no more effective than the old, and the problems seemed as irreducible as ever. Where, if anywhere, do we go from here?

Perhaps this remains to be said: although the discussion has been voluminous in quantity, it has taken place on a remarkably narrow front. It has usually been assumed that mental health services could be studied in isolation from both their historical and their

sociological contexts, and very little attempt has been made at cross-cultural comparisons. It may be that the diagnosis of our present problems is too narrow, and that as a consequence it focuses at the wrong points. The purpose of the present paper is to try to widen the discussion by looking at some of the contextual features that frame a familiar story.

Advance and Retreat

A basic key to understanding mental health policy is the recognition that it does not proceed in an orderly and wholly rational fashion. Models of linear progress are so deeply built into our analytical processes that it may take some effort to root them out and substitute models with a closer fit to the actual development of events; but the "advance-and-retreat" nature of mental health reform has long been observed in Britain (Jones, 1972). There are high points of enthusiasm and the mobilization of energy: the "nonrestraint" movement of the 1840s, when straitjackets and muffs and leglocks were abandoned, and the first small steps were taken in the development of activities and education for asylum patients; the development of psychiatry in the 1860s, when the "asylum doctors" first formed the Medico-Psychological Association, and began to define their professional expertise and responsibilities; the interest in poverty and the causal links with mental illness in the early years of the twentieth century; the interest in psychiatric social work and occupational therapy in the 1930s, together with the new inputs from psychoanalysis; the therapeutic community movement, the open-door movement and the use of the new psychotropic drugs in the 1950s. These were the peaks.

Between them (and since the 1950s) lie the troughs: periods of low motivation and confused purpose in which it was difficult to see any clear direction or to predict development. The same pattern has been recognized in the United States. In a foreword to the report of the Joint Commission on Mental Illness and Health (1961: xxix-xxx), Dr. Jack Ewalt raised the issue of why reform in mental health care was so slow, and why, "while each reform appears to have gained sufficient ground to give its supporters some sense of progress, each has been rather quickly followed by backsliding, loss of professional momentum and public indifference."

No great attention seems to have been paid on either side of the Atlantic to the problem of why this should be the case. The patterns of development in other areas of public social policy, such as the care of children or the care of the elderly, do not seem to exhibit similar tendencies—the flow of policy development is much more regular and even; and although penal policy has its own peculiar patterns, they tend to be circular—a reversion to principles thought to have been discarded, such as containment or retribution—rather than a peak-trough movement.

A possible source of explanation lies in the contradictory reactions of the general public to questions of mental illness. There is a level of rational *social response*: “Institutional care is bad, getting patients out into the community is good, somebody ought to make it possible, and to see that the resources and the services are there.” There is a very different type of response when it comes to finding the money out of taxation, to ordering priorities in such a way that the needs of the mentally ill come near the top of the list, to allocating scarce professional skill and resources. This is the *economic response*. Beyond this is the *personal response*, which is distinctly mixed in effect: “I would not personally like to go into a mental hospital, and therefore I am all in favor of care in the community, which is much more pleasant and less stigmatizing—provided, of course, that it is not in my neighborhood; but somebody ought to do something about these mad kids who are threatening society and ought to be locked up.”

It is not surprising that the result is a public opinion that is both volatile and unpredictable. By contrast, the reactions of the professionals are much more stable, for the three sets of responses all run in the same direction. The social response is accentuated by a knowledge of how bad institutional care can be, and how good community care can be if it is properly carried out. It is characteristic of the professionals that they see more clearly the best their profession is capable of rather than the worst it can descend to. The economic response is favorable because the professionals see their own field of operation more clearly than other people's, and have little difficulty in according it top priority. The personal response is favorable, because community care means new work opportunities, a more stimulating work environment, livelier colleagues, and possibly job promotion. If professionals become mentally ill themselves—they assume they would get special treatment, anyway.

Thus the two sets of responses are very different, and the professionals may have difficulty in appreciating the reasons why the general public does not see the situation in the same way as they do; but public attitudes to mental health are very complex. At the superficial level, there is already a conflict. Below that, one gets into a realm of stereotypes and half-knowledge, of instinctive and defensive reaction against the feared and the indefinable, which may take us right back to the witches of Salem and beyond to the excesses of the Inquisition. Out of these complexities comes a sort of polarization: a concern for the mentally ill, on the one hand, and a desire to ignore the whole problem, to sweep it out of existence, on the other. The result is inevitably a peak-trough effect over time.

Alarm-Mindedness

What activates public concern? It is rarely, if ever, the spectacle of a vital public service that is overworked and understaffed, operating in unsuitable premises on an inadequate budget. This has little news value. It is the sudden knowledge, publicized by the media, of a specific case in a specific hospital where concern can be mobilized for particular individuals, and other individuals can be blamed for it. Again, to quote the Joint Commission (1961): "Our first inclination in practice appears to be to expose in muckraking fashion, the alarming condition, enumerate the victims, name the 'villain.' But such an attack begs the question of what can be done."

In Britain, there have been many instances of this reaction, the most well-known recent instance being the St. Augustine's Inquiry (Report of the Committee, 1976), in which allegations of malpractice on hospital wards were made by a temporary member of staff who was a doctoral student in a nearby university; and the Normansfield Inquiry (Department of Health and Social Security, 1979), in which nurses went on strike, and a medical consultant was accused of unprofessional practice in giving massive drug overdoses to patients. He subsequently lost his post—but was not, however, removed from the medical register. The danger, of course, is that the public diagnosis does not reach the real nature of the malaise, and the solution does not get near tackling its causes. It is very easy to rouse public indignation on such issues; but when the particular issue

is over (and no issue has a very long life in the press or on television) there is no dynamic left to carry on the movement.

The Credibility Gap

As a result of these contradictory movements, these sharp but totally inadequate public attacks on an already overburdened service that is never able to come anywhere near the unrealistic expectations placed upon it, there is a permanent credibility gap between public policy, as enunciated in documents written by politicians, civil servants, and professionals, and the way in which the services actually operate at the level where the individual patient meets them. There are two sides to the coin: on one side are the achievements, the validated successes, the hopes, and the aspirations. Flip the coin, and there are the failures, the inadequacies, the frustrations that make up the service as most patients encounter it.

The result is a gap of no mean proportions, and one that is likely to continue as long as we focus our efforts on what we want (a good, caring service for patients) rather than on how to get it, and how to identify and overcome the obstacles to it.

The next step must be to define the obstacles: to try to see clearly what factors prevent us from having the mental health services we would like.

What's Wrong?

Though many differences can be observed in the structure and the operation of mental health care in Britain and in the United States, certain common features can be noted. Deinstitutionalization is the most obvious of these: a steady process of reducing patient populations, which has sharpened the focus on community care. Together with this goes an impatience with the slow development of community facilities, and a recognition that, in a well-organized and humane service, the community services ought to have been well on the way to successful operation before the process of sending the patients out was begun. Because this was not done, many patients have been discharged to unsatisfactory home situations, to inade-

quate or even nonexistent professional care, to pressures and problems that have soon sent them back through the revolving door (Klerman, 1977; Bachrach, 1976). Curiously, although everyone knows this to be true, and there is no lack of documentation at the journalistic level, there are no major research projects of academic respectability that show either the extent of the need or the extent of the failure. Can it be that the public authorities and the allocators of research funds are more interested in publicizing successes than in analyzing failures?

There is a great deal of research material of statistical nature. Unfortunately, this is based on agency records. We know how many times the agency opens and closes a file, how many admissions and discharges are recorded. Some quite sophisticated statistical work can be carried out on such figures. Unfortunately, the material does not give us sophisticated answers if we cannot relate it to individual patients and their life experiences. We know very little of how individuals experience the service—what causes them to seek hospitalization or consultation, what they do between episodes (increasingly brief) of agency contact, what agencies they encounter outside the mental health field, the part played by neighbors and kin in supporting them or in making another treatment episode more probable. Until we organize longitudinal tracer studies that will give us this kind of information—systematic social research on a large scale, and in sufficient depth to give us sensitive answers—we cannot even begin to define the nature of the problems.

One obstacle to change, therefore, is sheer lack of knowledge. We make assumptions about service provision in the light of what the services have to offer, not in the light of what the patients need.

In both countries, the complexity of this situation is compounded by the rapid growth of the helping professions. Psychiatrists have an acknowledged position deriving largely from their membership in the medical profession. Nurses, social workers, and psychologists have developed their professional organizations more recently. Each has become more conscious of professional opportunities and skills, perhaps less conscious of professional limitations. Inevitably, there have been some strains with the medical profession, most of whose members have been socialized into a set of professional expectations that include the unquestioned right to leadership of multiprofessional teams. But while medically trained psychiatrists were the unquestioned leaders in the hospital setting,

they have a more uncertain position in community-based services, where many other kinds of expertise and insight are relevant, and their medical, largely hospital-based training is to some extent at a discount. A recent report from the British Department of Health and Social Security (1975) (formerly the Ministry of Health) refers to "appeals for help which go unanswered while officials debate the boundaries of professional responsibility."

Paradoxically, the growth of professional standards, in one sense a protection to patients, is also a disadvantage to them, because it diverts energies and activity into avenues not directly connected with their care, and restricts the services offered. Another obstacle to change, therefore, is the professional tension that has been set up, and at present remains unresolved. In Britain, this inhibits the development of an integrated community service, because psychiatrists now play a very small part in care in the community, which in 1970 was handed over to the social-work-based social services departments, under the provisions of the Local Authority Social Services Act. In the United States, there have been many more sustained attempts at interprofessional teamwork (in which psychologists make a much greater contribution than they do in Britain), but the strains in trying to create a metaprofession of mental health professionals out of a group of people with disparate knowledge bases are still very evident (Feldman, 1978).

A third problem is the unclear nature of the scope of the mental health field. At its narrowest, mental health work is orthodox psychiatry: the "treatment" of people who fall within accepted diagnostic categories as a medical specialism. Once we depart from that narrow base, it extends into many other areas, most of them well outside the medical field and beyond the scope of medical training. When we begin to talk about "preventive work" or "the promotion of positive mental health," we involve notions of social well-being and community strengths and weaknesses, which require all the resources of the sprawling and unsatisfactory social sciences as well as some that they do not yet possess, if they ever will; for social science is an inexact and messy business, where it is much easier to analyze than to prescribe.

If mental health care is not just orthodox psychiatry, what are its practical limits? Where is the cutoff point between being mentally ill (whatever that is taken to mean) and simply being an unhappy human being in an unsatisfactory social environment? However high

our aspirations, mental health is too slender a base from which to tackle all the ills of society—unemployment, poor housing, loss of human dignity in a mass society where the forces of social cohesion are undervalued and the forces of disintegration appear to become stronger every year. Mental health cannot right all social wrongs, remedy all social injustices, remove all social and personal pressures. Although some of the staff of community mental health centers have gone out into their local communities in a crusading spirit, they are likely to find, like other teams of reformers, that many of the conditions they want to remedy go deep into the fabric of society, and cannot be tackled on a local or piecemeal basis.

Nevertheless, the cutoff point is difficult to find. We are all conscious of living in a society where many people have jobs that offer no personal satisfaction, and are basically alienative—or no job at all, with all the damage that prolonged unemployment can do to personal identity and esteem; where, for many and complicated reasons, family life is often unstable and frequently tenuous; and where the intensity of the search for values, at least among the intelligentsia, is paralleled only by the lack of success in finding them. Are these mental health problems? They are, in the sense that they provide some of the factors in mental ill health: they are not, in the sense that the mental health movement cannot provide the answers or contribute more than a fraction to the solution of the problems.

A further problem is the curious effect of the civil liberties movement on the mental health field. Until some ten or fifteen years ago, it was generally accepted that the right way forward in the reform of mental health legislation was to reduce legal requirements to an acceptable minimum, leaving as wide an area as possible for professional discretion. Paradoxically, the civil liberties movement has concentrated on the exact definition of legal requirements, in the hope of reducing them to a minimum (Chambers, 1972; Gostin, 1976). It is by no means clear that this is always the outcome. The definition of exact legal categories and procedures may increase the rigorousness of the machinery, and make it impossible to adapt it to particular cases. If discretion and flexibility have their dangers in allowing occasional undesirable practices to occur, the dangers of an inflexible system where one is required to apply rules and not to use common sense seem equally great, if not greater. The precise specification of hospital admission procedures and the categories for treatment of various kinds is not a protection to the patient; it is

another means of stultifying and routinizing service provision (Jones, 1977).

In summary, we are trying to find solutions to problems we cannot adequately define, in an atmosphere of interprofessional tension that leads to unrealistic claims and the diversion of scarce resources. We are uncertain about the scope of the field, the keenest social reformers of the day are more of a hindrance than a help, and the whole debate takes place against a background of adverse social conditions and capricious and tenuous public interest. That is probably a fair description of the things that have gone wrong since we began the process of deinstitutionalization. Now to look at the things that have gone right.

What's Right?

Nobody wants to bring back the old mental hospital system. It served its day—and perhaps it was inevitable in a nineteenth-century society where community supports were minimal, and there was no other means of providing for the casualties of a highly mobile and yet often highly intolerant society. As the asylums grew in size, so they increased in rigidity, and became distinct subcultures, with their own ethos, their own way of life, and their own social hierarchies. The effects of this system in creating institutionalized personalities have been very fully described (Goffman, 1962; Barton, 1959; Bastide, 1962), and there is some justification for the view that, whatever the dangers and shortcomings of life in the community, what the community was likely to do to expatriates could not possibly be worse than this.

It is curious how limited has been the recognition that this movement has been part of a much wider movement in sociology that attacks institutionalization of all kinds, and that there are parallel developments in prisons, hospitals for the chronic sick and the old, and many other institutions. “Antipsychiatry” and “deinstitutionalization” have been paralleled by radical criminology and radical social work since the late 1950s (Becker, 1964; Taylor, Walton, and Young, 1973; Throssell, 1975; Bailey and Brake, 1975), and the movement has shifted into a new phase in recent years, with the slogan of “decarceration” (Rothman, 1973). The report of the Committee for the Study of Incarceration (Hirsch, 1976) begins in

the field of penology, but promises future developments that focus on the mental health field. The borrowings from this wider literature by mental health professionals have so far been few, but there is a good deal to be learned from cross-service comparison.

In mental hospitals, there were special features that made the reduction of patient populations possible. The decision to do so in the 1950s was made not only on ideological but also on clinical grounds; advances in pharmacology made it possible to control symptomatology and reduce distress to patients and their relatives. Although some of the claims made for new drugs were exaggerated, and the effect of many may be principally palliative, they still made normal living possible for many patients who could not previously have sustained it (Carstairs, 1961; Brill and Patton, 1961). The decision was taken partly on economic grounds also; most mental hospitals were old, expensive to maintain, and highly visible, a constant reminder of outdated standards and poor quality provision. They had been comparatively easy to erect at a time when building costs were low. By the late 1950s, they were a standing reproach, and the cost of replacement, at a time when building costs were soaring, was prohibitive.

Some of the saving may have been illusory. Training also costs money, and the corollary of a care system not institutionally based is a dynamic and highly specialized treatment system; but diversification of services means that the costs fall on different budgets; they are not seen as a unitary item of expenditure in the same way as building costs.

So, for a variety of reasons that fortuitously came at the same period, we began to discharge into the community patients who had in some cases spent many years in an institutional setting—not always with due preparation, and not always to stable or suitable situations. The length of stay in hospital for many new patients was drastically shortened, not always with good results, but the results were good enough to make it clear to the general public that admission to hospital was not a one-way ticket. Finally, many patients who previously would have had to face a period of hospitalization were treated wholly in the community.

The effects in both Britain and the United States have probably been beneficial for patients with comparatively mild or short-term conditions; they have been spared much of the stigma that formerly attached to psychiatric treatment, and have been able to recover

their social balance without the trauma of being labeled and separated from the community. Many more people with comparatively mild conditions have come forward, when previously they perhaps would not have received any treatment.

The argument is currently being advanced that this is a wrong use of resources, that the seriously and chronically mentally ill have suffered neglect in the remaining institutions, while the best services and the most up-to-date treatment have been available for those whose need is less. This is a persuasive argument, but probably a false one. In the first place, it is by no means certain that the people who use the argument would really spend money on the back wards of mental hospitals if it were not spent on the community services; it seems only too likely that good reasons would be found for diverting money to pediatrics or to the apparently more urgent field of acute general medicine. Second, the argument underestimates the degree of need in the community; there is a concealed argument that people who receive care in the community are really not mentally ill at all, and could perfectly well look after themselves. This is by no means true. The whole concept of prevention and early treatment implies reaching out to meet patients before they deteriorate into long-term "cases" and treating them while their personalities are still relatively intact. Third, there is no reason why the argument should be presented in terms of binary choice: we care either for the chronically mentally ill or for recent and milder cases. What we need is a policy that takes adequate care of both.

Overall, then, the effects of the community mental health care movement have been better than those of care wholly within an institution. However, it is misleading to talk of "community mental health care" as though the developments in the United States and Britain over the past two decades have been similar in character. They have in fact been very different.

Community Care in Britain

When the Milbank Memorial Fund sent a distinguished team of American psychiatrists on a study tour of British mental health services in the late 1950s, they found a community care system that already seemed well advanced (Milbank Memorial Fund, 1960). Dr. Ernest Gruenberg and Dr. Frank Boudreau praised the "open

hospitals," where "the most startling feature of the British experiment has been the elimination of the locked ward" and "rather than spending almost all of their seriously handicapped lives under close twenty-four hour a day supervision in the hospital . . . patients now spend most of their mildly or moderately handicapped lives in the community" (Milbank Memorial Fund, 1960; 5-6). Dr. Pleasure reported that they had "discovered that the mental hospital was not the exclusive site for psychiatric treatment, but served as a center for community-based mental health programs which included consultation with family doctors, clinic treatments, and day care as a substitute in many cases for certification" (Milbank Memorial Fund, 1960: 25). He felt that the dignity of the patient was markedly enhanced, and that what they had brought back was not "a bag of new tricks" but "changed attitudes" about the degree of freedom that patients could be allowed and the amount of responsibility they could take.

At the same time, they expressed certain reservations. Dr. R. C. Hunt felt that all the advances were in connection with the short-stay patients, and the wards for what were then still called "refractory" patients were much the same in both countries (Milbank Memorial Fund, 1960: 76). Dr. Boudreau stressed that the open-door policy was not in itself a therapy—it was only the creation of a more favorable milieu in which therapy could take place (Milbank Memorial Fund, 1960: 13) (the same point was being made about the nonrestraint system back in the 1840s). Dr. Hunt felt that, although the system might work in Britain, it was probably not transferable: "The nationalization of all health and welfare services in Britain gives them the machinery for pulling all the needed things together in one package. Because we do not have this machinery in our society, we are faced with the problems of communication and of organization between diverse, separate agencies so as to pull them into a continuum" (Milbank Memorial Fund, 1960: 76).

Today, this statement seems distinctly ironic; for it was the British, precisely because of the nature of their National Health Service Organization, who were to develop a system (or nonsystem) of "diverse, separate agencies," and the Americans, precisely because of their lack of suitable existing machinery, who were to be able to pull "all the needful things together in one package."

The British (at least the Department of Health and Social Security, which is responsible for mental health in England and

Wales—the Scottish and Northern Irish systems are somewhat different) rested on their laurels. The machinery of the National Health Service existed, and was due for revision. The machinery of locally based social services also existed, and was due for revision. There seemed to be no compelling reason to develop specialist mental health agencies, and indeed the whole philosophy of the sixties and early seventies was against specialism. The developing professions of social work and nursing experienced a pull to the center as they mobilized their forces for the coming battle with the medical profession. Social work became generic. Psychiatric social workers, formerly a small but highly valued group of specialists, all but disappeared, and the mental health element in social work became devalued as new methods in community work, group work, and then the unitary approach, which claimed to make all methods of approach available from a casework base, became popular. Psychiatric nurses, once a group very distinct from generally trained State Registered Nurses, were gradually assimilated into the structures and ethos of the Royal College of Nursing. Psychiatrists, finding that their former unchallenged status as leaders in the mental health field was less secure, also began to move toward the center of the medical profession, becoming less interested in social and community methods of care, and much more firmly attached to pharmacology as their distinctive tool (after all, only they could prescribe, anybody could listen).

In 1971, after several years of debate and discussion, in which the Seebohm Report (1968) was the seminal document, the first major change took place. County social services departments were set up, and took over all the mental health work formerly associated with health departments. This abruptly severed the links with psychiatrists, which in some cases had been firmly established, and placed the community services, with the exception of psychiatric clinics (mainly based in hospitals), in the hands of social workers. This was so unacceptable to the medical profession that in more than one area they refused to hand over patients' records, on the ground that they were subject to medical confidentiality, thus leaving the social work staff with no information on which to commence their work—not even names and addresses. Psychiatrists complained bitterly about the lack of liaison, and the inability of the new generically trained workers to cope with the special needs of mentally ill patients. (One of the problems was that most of the field

social workers were newly trained—social workers with any weight of experience went into the newly created management hierarchies of the social services departments, and ceased to do field social work.)

In 1974, after the National Health Service Reorganisation Act of 1973, the National Health Service was reorganized on a basis that left no distinctive organization for the mental health services: regional health authorities, area health authorities, and district management teams (the smallest units, covering populations of about 100,000) all dealt with all services for both physical and mental health (Department of Health and Social Security, 1972). Proposals were made for mental health care planning teams, but very few authorities actually established these. In 1975, a government report on *Better Services for the Mentally Ill* (Department of Health and Social Security, 1975) expounded the new philosophy. There were many problems. Mental hospitals, though reduced in numbers of beds, dealt with a mounting volume of work, and there was no prospect of abolishing them altogether (a prospect that had seemed possible in the heady days of 1961, when the deinstitutionalization policy was first announced). Staffing was often “less than adequate” and “basic facilities and amenities” were often lacking. Community facilities had to be built up from their “present minimal levels” and there was a cautious note about the limits of community care in terms of public tolerance—the demands made on the community “must not be greater than the community can accept.” Nevertheless, it was argued that the new principles were right, and that any failures were “at the margin.”

The new principles are:

1. “*Integration*,” which means that the mental hospital system is merged with the general hospital system, and the mental health community services with the general social services. Two successive secretaries of state spoke with approval of the closer incorporation of psychiatry into general medicine.

2. “*Community care*,” which in practice means the provision of small residential homes and field social work by the local-authority social services department. This is virtually cut off from the hospital services, the outpatient clinics, and the day hospitals run by psychiatrists.

3. "*The primary care team*," which means the services of a family doctor, a health visitor (health educator), and a home nurse, none of whom has any training in mental health work, and all of whom are strongly oriented toward the treatment of physical illness.

Even this brief description should make it clear that these principles destroy mental health as a specialism. There may be "services for the mentally ill" but it is exceedingly unlikely that they will become "better services for the mentally ill" if there is no administrative focus, no forum for policy debate, and no impetus to professional development. The result is that the British services are now fragmented, and to a large extent the personnel are demoralized.

Community Mental Health in the United States

The United States had no National Health Service to graft mental health services on to, and the county social services (preoccupied with existing responsibilities, in casework and the administration of financial benefits, as their British equivalents are not) seem to have had no great interest in developing specific systems of mental health care. Consequently it was necessary to invent a special piece of administrative machinery, and the community mental health center (CMHC) was the result. It has made possible a dimension to the mental health movement that simply does not exist in Britain: a specialist agency with staff who have been able to pool their different professional skills and to reach out into the community in new ways (Barton and Sanborn, 1975; Beigel and Levenson, 1972; Karno and Schwarz, 1974). CMHCs have become integrated into specific communities, and become part of their living pattern. "Outreach" has led to the development of specialist youth work, housing programs, work with the elderly and with ethnic groups, store-front and street psychiatry—all concepts that are unknown in Britain, where the psychiatrist still sits behind his clinic door, and the social worker goes into the home with no specialist mental health knowledge. The CMHC has made possible experiments in public participation, in

mental health education, in community action—all inconceivable in Britain in the present situation.

CMHCs have had their problems, and some of them continue, and some of them may be incapable of resolution. No administrative solution has all the answers. But CMHCs have generated an enthusiasm and mobilized an energy of which the British mental health field is now sadly in need.

Conclusion

Deinstitutionalization occurred at roughly the same time in Britain and in the States. The reasons it happened, and the problems it generated, were very similar; but the solutions have been different, and the divergence between the two systems grows wider every year. On a recent visit to the States, I was told many times that “the British are ahead in mental health.” This may have been true fifteen years ago, but it is not true now. The administrative changes of the past eight years have been major ones, undertaken for good reasons and successful in many other fields, but disastrous to the progress of the mental health movement. I was also told that the National Health Service was entirely admirable, and that if the United States could develop a similar service, it would solve all problems. This is just wishful thinking. Most of the problems of the hospital services—spiralling costs, outdated plant and equipment, shortages of physicians and other personnel, training bottlenecks, labor problems—exist equally on both sides of the Atlantic. There is no short cut to a good service, and no cheap way to achieve it, either. So far, the United States has made a much better job of the business of deinstitutionalization. It is to be hoped that the peak of achievement in the past few years can be maintained, and that there is not a trough ahead. Pressures toward an “integrated” health service could destroy the benefits of mental health specialization as surely in the States as they already have in Britain.

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*Includes bibliographical references to many other relevant sources.

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