The Chronic Mental Patient in the Community

Formulated by the Committee on Psychiatry and the Community

Group for the Advancement of Psychiatry

This publication was produced for the Group for the Advancement of Psychiatry by the Mental Health Materials Center, Inc., New York.
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STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

The chronic mental patient in the community was formulated by the Committee on Psychiatry and the Community which acknowledges on page 287 the participation of others in the presentation of this report. The members of this committee are listed below. The following pages list the members of the other GAP committees as well as additional membership categories and current and past officers of GAP.

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COMMITTEE ACKNOWLEDGMENTS

The Committee on Psychiatry and the Community prepared the report on the Chronic Mental Patient in the Community with the assistance of three GAP Ginsburg Fellows: Kenneth Minkoff, M.D., Richard Moskovitz, M.D., and John L. Walker, M.D. Their contributions, reviews of the extensive literature, and thoughtful recommendations were of inestimable value.

Mrs. Morton Phillips ("Dear Abby"), nationally syndicated newspaper columnist, participated throughout in the formulation of the report, offering many substantial and editorial recommendations. She solicited through her national column reports of former patients and members of their families, describing the experience of re-entry into the community following a three-month or longer period of mental hospitalization. About 350 letters were received and carefully studied by the Committee. A representative sample of these moving testimonies is incorporated in the body of our report.

Alexander S. Roigowski, Chairman
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INTRODUCTION

For one hundred years the most seriously and chronically disabled mental patients in the United States were incarcerated in large institutions for part or for the rest of their lives. Their numbers increased steadily, peaking at 558,922 in 1955. Since then, the number has consistently decreased; in 1976 there were only 193,436 patients in state and county psychiatric hospitals, a reduction of 65.4 percent despite a marked increase in our nation's population.

This dramatic development was due to several factors: a therapeutic breakthrough, an increase in psychiatric outpatient and general hospital facilities and, more fundamentally, a combination of political and social changes. Use of the new psychotropic agents allowed many patients requiring long-term care to be discharged to community settings after relatively brief hospitalization. Other patients who would have been sent to a mental hospital a few years ago can now be maintained on drug therapy in local community facilities.

* The terms “patient,” “chronic mental patient,” “ex-patients,” and “former patients” as employed in this report are loosely defined and refer—following Bachrach's recommendation—to “those individuals who are, have been or might have been, but for the deinstitutionalization movement, on the rolls of long-term mental institutions, especially state hospitals.”

* The term “community” is also loosely defined and refers to housing outside of hospitals. Patients so housed may be in a community even though, strictly speaking, they are not members of the community. Many observers of the American contemporary scene have pointed out that “communities” of the traditional kind, where people living in a defined geographic area know each other and establish a network of common concern and mutual support, have become rare in our country as a result of industrialization, urbanization and mobility. Thus a “return to the community” is often based on a nostalgic illusion.
New legislation designed to protect the civil rights of mental patients now limits involuntary confinement to periods when they are considered to be dangerous to themselves or others, or "gravely disabled." Changes in welfare legislation have introduced support payments for the mentally impaired so that they can be maintained in the community even if they are unable to earn their livelihood.

These developments reduced the state hospital census so drastically that some states have closed or considered closing some or all of their state mental hospitals. They seem to have ignored the fact that admission rates remain high, readmission rates have rapidly escalated and the quality of care provided for ex-patients in the community is obviously deficient. Advocates of deinstitutionalization declare that the chances of recovery for the mentally ill are always increased by a return to a more "normal" setting. Many patients have fared better when removed from the isolation of the hospital, but for a substantial number the outcome has been tragic. The quality of their lives is worse than it was in the hospital. Although they are now permitted to reside in the community, their housing is poor, they lack access to activities or rehabilitation, and they are often prey to exploitation. As the following questions and answers indicate, deinstitutionalization is far from achieving its desired goals:

Are the formerly hospitalized patients really members of any community? ⁴

Those ex-patients who have become reintegrated into the community tend to disappear from sight, and it is difficult to determine their number. A substantial number have not become integrated. For example, among 34,000 residents of the town of Long Beach, on Long Island, New York, there were, in 1974, 712 former in-patients from state mental hospitals. The townspeople called them "walkers" because they were often seen walking tranquilized and aimlessly on the boardwalk. Their strange appearance and bizarre behavior made the other residents fearful; nobody in Long Beach accepted them except the hotel owners who needed the business. They strained the public services and clogged the emergency room of the local hospital. Except for state authorities, almost everyone was convinced that these former patients did not receive proper care and rehabilitation.⁶

Similar conditions exist in many other cities. Chicago's health commission referred to the near northside of the city as a "psychiatric ghetto" in which between 12,000 and 15,000 mental patients lived in nursing homes and unlicensed halfway houses.⁷ In Manhattan, there are about 25,000 unattached, lonely, chronically mentally disabled people who live in single-room dwellings, cheap hotels and rooming houses, surrounded by prostitutes, drug addicts, and petty criminals. They are at the mercy of society's predators. Moreover, new data suggest that the crime rate of these unattended ex-patients is higher than that of the general population.⁹

Is there protection and adequate follow-up care for this vulnerable group of people? ¹⁰

Some communities provide the care and protection needed, but too often there are cases as that of Mr. S. After spending seven years in Bronx State Hospital, he was discharged and placed in a hotel. He was referred to an overburdened local center, which could offer him only biweekly medication reviews. Mr. S. walked about aimlessly and ate from garbage cans. He was frequently robbed, beaten and exploited by deviants and local drifters and became increasingly frightened, disheveled, dirty and virtually mute. After his request for readmission to the state hospital was denied because
allegedly he could be “maintained” in the community, he attempted suicide.\textsuperscript{11}

**How does deinstitutionalization affect the families of discharged patients?**

Some former patients resume a constructive role in their families, but some affect their families very badly. An extreme example is Mr. FB, a 45-year-old farmer, who has suffered from auditory hallucinations and bizarre persecutory delusions since his twenties. He has repeatedly and severely beaten his wife and has been hospitalized a total of 30 times in state, veterans' and university hospitals. Once in a hospital and on medication his behavior rapidly improves, although he remains delusional. His mother who lives close by shares his delusions. She insists that he be discharged as soon as he improves and then discourages him from taking medication and keeping clinic appointments.

Since FB has not been gainfully employed since he first became psychotic, his wife and nine children are supported by welfare payments. Each time he returns home he stops taking medication and starts abusing his family physically and verbally until his wife, in self-defense, has him recommitted. After a brief stay, he is released and the cycle starts over again. All of his children have developed serious emotional problems and are being treated at the community mental health center.

The center staff pleads with the hospital to keep Mr. FB for longer periods to allow his family to stabilize. But current deinstitutionalization policies and legal restrictions make it impossible to hold him against his will as soon as he ceases to be acutely dangerous.\textsuperscript{13}

**What is the quality of life in community residential facilities?**

“While there is little or no evidence to suggest that the residents are mistreated or exploited by the operators of residential facilities, there is ample evidence of inadequate community facilities for their further rehabilitation, recreation or other support systems. At least half of the residents are not employable and their daily routine largely involves confinement to their home watching television and drinking beer.”\textsuperscript{14} This quotation from a study of the fate of deinstitutionalized patients in a section of San Jose, California, describes the quality of life of many ex-patients without family. Priscilla Allen, a former board and care resident, speaks of “the stifling atmosphere that frequently prevails in such environments,” where silence alternates with the sound of television. She found her residential facility “autocratic to the extreme,” a place where “to think free thoughts is to practice heresy.” She observes that “community facilities such as board and care homes are often as effective, if not more effective in institutionalizing patients, as are state hospitals.”\textsuperscript{15} They seldom provide occupational and recreational therapies, and they lack the resources for both treatment and movement toward rehabilitation that can be found in state hospitals. Unhappily, her experience is the rule rather than the exception.

**Has the massive transfer of aged state hospital patients to community facilities better served their needs?**

Between 1969 and 1974 the number of aged patients in state hospitals declined by 56 percent, even faster than the number of younger patients.\textsuperscript{16} Local facilities in which they were placed, however, often offered less care and protection...
than the large institutions from which they had been discharged.

As the result of a general policy, Mr. K, a 77-year-old resident of a mental hospital was discharged together with many other aged patients. Representatives of the boarding homes visited the hospital to “bid” for the right to care for the old people. Mr. K was a “good patient” since he was entitled to Social Security benefits and also received regular payments from an ILGWU pension. Like many elderly patients, he had no family of his own and the nursing home people drove him to his new lodgings which only a few months earlier had been a very nice motel. That was the last time he went out. There was no recreation or social program; there was only TV. Usually Mr. K had no one to talk to, so he soon stayed in bed all day. There was no psychiatric personnel to recognize his deepening depression. He was especially confused at night because he was all by himself. When he caught a cold, a doctor came around and prescribed some pills which were administered by an untrained attendant. A month later he died. His case is typical of many cases.17

We can see, therefore, that the facts of deinstitutionalization, reintegration and community care for the ex-patient often differ considerably from the hopes and assumptions of optimistic legislators, administrators and mental health professionals and from the claims of enthusiastic adherents to the anti-psychiatry movement, all of whom seem to overlook the practical realities of these complex issues.

Most psychiatrists, unfortunately, have neither taken enough interest nor exerted enough leadership in problems presented by deinstitutionalization. At a time when strong societal forces were changing the roles of mental patients and of mental hospitals which historically constitute our primary responsibility, we were preoccupied with the established ways of practicing and teaching our profession.

* * * * * * * * * * * * *

This report examines both the advantages and the adverse consequences of the new policies for deinstitutionalization. We strongly support the concept of community care where clinically indicated. We believe that properly implemented it provides the best hope for most mental patients. We fully endorse the “principle that mentally disabled persons are entitled to live in the least restrictive environment necessary and lead as normal and independent a life as possible.”7 But we are disturbed by evidence that the problems of reintegration are being ignored in so many localities. We are concerned because the lessons of the past are not being heeded and the errors of the past are being repeated. We foresee grave consequences for our patients and serious implications for our profession if as a nation we continue to fail to apply the remedies available to us to provide quality care and humane treatment for the full spectrum of our chronic mentally handicapped fellow citizens.

REFERENCES
2. Mental Health Statistics Note #132 (July 1976), “Provisional Patient Movement and Administrative Data,” State and County Psychiatric Inpatient Services, July 1, 1974–June 30, 1975, Division of Biometry and Epidemiology, NIMH.
5. ———. The Long-Term Patient in the Era of Community Treatment, Archives of General Psychiatry 34 (June 1977) 679–682.
17. Ibid.

Before 1841, a few psychiatric patients—those who could pay private fees—received "moral treatment" in settings such as the Pennsylvania Hospital (1756), the Friends Asylum (1817), McLean Hospital (1818), Bloomingdale (1821) and the Hartford Retreat (now, The Institute of Living) (1822). However, in the largely agrarian society of America, the majority of the mentally ill were confined either in poorhouses, jails or in one of the small number of state mental hospitals, and if they were kept at home they were often hidden and excluded from the life of the family.

**Reform in the nineteenth century: The state hospital movement**

In the 1830’s, the energetic and dedicated “American Pines,” Dorothea Dix, spearheaded a reform movement based on the humanitarian and therapeutic concerns that characterized “moral treatment.” Almost singlehandedly, she shamed state legislators into accepting responsibility for the care of people disabled by mental illness. She was “instrumental in founding or enlarging more than 30 state institutions,” which she hoped would provide “moral treatment” similar to that provided in private hospitals. Thus, she was

* "Moral treatment" is defined as "kind individualized care in a small hospital with occupational therapy, religious exercises, amusements and games, a healthy psychological environment, and organized group living... in which spontaneous improvement could take place."
responsible for a dramatic shift in the main locus of treatment from communities to state hospitals.

Ms. Dix's dramatic appeal for humane treatment impressed the legislators to whom she spoke but, significantly, they did not act until they discovered that the new approach would also save money. As Henry observed in 1941:

One of the most serious objections to the adoption of the state mental hospital system was the increased cost of maintenance. However, it was learned that large groups of patients could be maintained more economically and this consideration, rather than the welfare of the patients, still determines the policies of legislative bodies.⁶

From the beginning the new mental hospitals were not given adequate operating budgets. The Civil War, the subsequent national financial crises, and the nation's rapid population growth intensified legislative concerns for economy. It soon became evident that Dorothea Dix's goal of providing moral treatment for the poor was not to be realized. In less than 50 years most of the state hospitals became enormous, poorly-financed barracks-like settings that encouraged regression rather than recovery. Many were built in remote places to provide a rural retreat and also because the land was cheap. The social isolation, the lack of professional resources and stimulation, and low salary scales made it hard to attract qualified psychiatrists. Consequently, although the mentally ill were less often "bound with galling chains,"¹ they were ignored and neglected, warehoused out of the consciousness of most citizens, and far away from their families who lost all contact with them and soon forgot them.

For nearly a century, except for a few, mostly private, settings, care in mental hospitals lost its therapeutic orientation and became almost exclusively custodial, virtually ignored by legislators and citizens alike. The conditions in state hospitals cast a pall of pessimism over the profession of psychiatry. The enthusiasm for moral treatment was lost and most psychiatrists accepted the fatalistic view that mental illness was inherited and untreatable.

Reform in the twentieth century: The movement towards community treatment

A break in citizen apathy was heralded by Clifford Beers's autobiographical book, A MIND THAT FOUND ITSELF (1909).⁷ The stir it created led to the formation of the National Committee for Mental Hygiene. Gradually the Committee and its successor citizen organizations succeeded in arousing public concern about the treatment of the mentally ill. Their efforts were reinforced by such exposés as Albert Deutsch's THE SHAME OF THE STATES (1948).⁸ The Great Depression and the New Deal led to greater public acceptance of governmental responsibility for all those unable to help themselves including the mental patients.

Some time after Beers's book was published, new psychobiological and psychoanalytic theories began to restore optimism about the efficacy of psycho-social forms of treatment as well as about the possibility of preventing mental illness. These hopes encouraged the development of child guidance and other community clinics, but had little effect on state hospitals where the care remained mostly custodial.

During World War II psychiatry became more acceptable to physicians. Examinations at induction centers revealed that more than the expected number of inductees suffered from emotional and mental disorders. Many military physicians received special training to be able to treat the large number of psychiatric casualties. The rapid return to front line duty of psychiatrically impaired military personnel following early and intensive field hospital care encouraged the post-war development of psychiatric units in community general hospitals.
After the War, public interest in mental health issues led legislators to support the funding of treatment, training and research efforts organized under the National Mental Health Act of 1946. Stimulated by the National Institute of Mental Health (NIMH), the numbers of professionals in psychiatry, psychology, social work and psychiatric nursing increased dramatically during the 1950's and early 1960's. Community acceptance of the mentally ill was aided further by the discovery of psychotropic medications which often controlled disturbing psychiatric symptoms. These developments made it possible to plan for the large-scale treatment of psychotic patients in the community.

Meanwhile, American psychiatry was challenged by developments abroad. Community mental health care in the United Kingdom was fostered by the National Health Service in the late 1940's. Similar movements in other countries emphasized the importance of the patient's family and other community supports for the creation of a "healthy psychological environment" in which modern moral treatment could be effective.

The Joint Commission on Mental Illness and Health

By 1955, Americans were sufficiently concerned to prod Congress into passing a Mental Health Study Act that established a Joint Commission on Mental Illness and Health and convened leaders in psychiatry, psychology, social work, education and the social sciences for a

nationwide analysis and reevaluation of the human and economic problems of mental illness and of the resources, methods, and practices currently utilized in diagnosing, treating, caring for, and rehabilitating the mentally ill . . . ."7

The authorizing resolution included the observation that "experience with certain community outpatient clinics and rehabilitation centers would seem to indicate that many mental patients could be better treated on an outpatient basis at much lower cost than by a hospital" [italics ours]. Thus, from the beginning of the federal thrust towards community treatment, legislators were attracted by the hope that community care was not only better but also cheaper than hospital care.

The Joint Commission's 1961 report, ACTION FOR MENTAL HEALTH,8 advocated improvement of the mental hospitals by reducing their size, augmenting their resources, and extending their services into the community. It relied heavily on the views of Robert C. Hunt, then Superintendent of the Hudson Valley State Hospital, who asserted: "The . . . disability associated with mental illness is to a large extent superimposed [by hospital care]. [It] is preventable and treatable. . . Some of the treatment functions and most of the custodial functions of the hospital should be returned to the community."9 Accordingly, "to save the [hospitalized] patient from the debilitating effects of institutionalization," the Commission recommended returning him "to home and community life as soon as possible." There should be maintained with the help of "day hospitals, night hospitals, aftercare clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services and expatient groups . . . so long as they are soundly conceived, well staffed, and operated as part of an integrated system of mental patient services."10

Despite the emphasis on economy in the enabling legislation, the Commission recognized that an effective community program would be expensive. Its final recommendation was that, "Expenditures for public mental patient services should be doubled in the next five years—and tripled in the next ten . . . [because] only by this magnitude of expenditures . . . can outpatient and expatient programs be sufficiently extended outside of the mental hospital into the community."11
The government accepted many findings of the report, but it failed to heed the crucial recommendation that increased funding would be required.

**President Kennedy's “new approach”**

In 1963, President Kennedy categorized mental hospitals as "shamefully under-staffed, overcrowded, unpleasant institutions from which death too often provides the only firm hope of release" and proposed in the first and only message about mental illness that any President ever sent to Congress:

> ... a new approach to mental illness, [replacing] the cold mercy of custodial isolation ... by the open warmth of community concern and capability ... Prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients ... Central to a new mental health program is community care. Merely pouring federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference ..."\(^{15}\)

This dramatic statement, using what Feldman\(^{14}\) has called political overkill (of state hospitals) and oversell (of community services), reflected the optimistic messianic mood of the period. The fiction was maintained that adequate community care would be even cheaper than the inadequate mental hospital care that the President excoriated.

The experience of the British was also ignored; by that time they had discovered that community care was not the panacea they had anticipated when they developed community care for the mentally ill following the National Health Service Act of 1948. Optimistically they had predicted that by 1975 the number of mental hospital beds would be reduced by 50 percent and that the "archaic mental hospital of the past" would eventually disappear. Interaction between the sick mental patient and his environment, however, turned out to be more complex than anticipated. In 1964 Bennett warned "that patients must be carefully selected for community care, not indiscriminately discharged from the hospital."\(^{15}\) Observing that the success of community care could not be measured simply by the reduction of the hospital resident population, he pointed out that virtually no one was studying the distressing effects on the families. By this time British halfway houses were already "sitting up" with chronic patients, and the quality of care in the community was often worse than in the back wards of mental hospitals.

In the United States, many mental health professionals joined legislators in their unrealistic hope that effective community care could reduce over-all expenditures, especially when combined with preventive measures which they believed would lower the incidence of mental illness, and might even eliminate the need for hospitalization. Optimism about the efficacy of preventive measures persisted despite the lack of confirmatory evidence. Hunt observed, "Our hopes of preventing mental illness by mental health education and child guidance clinics have been disappointed and there is no convincing evidence that anyone has ever been kept out of state hospitals by such measures."\(^{16}\)

**The neglect of aftercare**

The Joint Commission had strongly recommended a detailed community aftercare program of psychiatric and psychopharmacological services and rehabilitation for discharged hospital patients in preparation for their autonomous and socially integrated existence. But the legislators who drew up Public Law 88-164 did not include aftercare among the five "essential" and legally required services. Aftercare was relegated to the optional category; centers were required only to concentrate on short-term hospital care, partial hospitalization, emergency and out-patient services, and community consultation and education. These "essential"
services consumed most of the resources of the community mental health centers and left little for aftercare, perhaps the most essential service of all. Finally, in 1975, Congress made aftercare services mandatory but, true to tradition, failed to authorize the necessary additional funding.

**Deinstitutionalization**

Inflation raised the costs of hospitalization and led state legislatures to intensify pressure on administrators of the discredited state hospitals to reduce their in-patient census. When welfare regulations made socially disabled persons eligible for Aid to the Disabled (ATD) and subsequently for Supplemental Security Income (SSI), the state saw an opportunity to reduce their fiscal responsibility. They discharged hospitalized patients in large numbers and transferred the burden of their care to the welfare system and the community, rationalizing their policy by claiming that care in the community was not only cheaper but better.

The expectation that fewer hospital patients would result in a surplus of hospital funds and hospital staff which could then be directed to patient care in the community did not materialize. Hospital operating costs rose due to inflation and other factors such as increased labor costs. Also, savings previously produced by in-patient labor were reduced. The staffs, used to working in hospital settings, were unwilling or unable to adapt to community care settings. Furthermore, states were caught in the inflationary spiral, and community care was shortchanged.

The first wave of discharges were the least disabled, most motivated and best prepared for reintegration. Many were rehabilitated at relatively low cost. Thus, initially, the program change seemed to be a forward step. But as deinstitutionalization continued, accelerated in part by the right-to-treatment movement which required hospitals to provide a standard of care beyond their resources, a different category of patients was returned to the community. These were the chronically disabled, functionally marginal and profoundly alienated. Few if any communities were prepared to provide the extensive community care services these patients needed. Many of these patients had been hospitalized for so long that they had lost all contact with families and friends; they had neither families nor communities to which to return.

**Life “in the community”**

In many areas of the country, the results have been that many of the patients discharged now live in unlicensed, inadequately supervised boarding homes or single room occupancy hotels, supported solely by welfare. Without the necessary resources to provide rehabilitation, the community has no choice but to let these patients sit by themselves, with nothing to do and no one to care. The President of the Borough of Queens in New York said, “The snake pits are being transferred from the institutions to the neighborhoods.”

In reply to a published request by “Dear Abby,” the syndicated columnist, for personal experiences related to mental hospitalization, one woman wrote about her 30-year-old daughter who had been mentally ill for 12 years:

> She is not capable of taking care of herself. She is helpless, yet again and again they release her . . . each time they do not seem to have a record of her case and know little about her history. . . . She was catatonic just recently when they found her in an apartment where she lived with a man she met in the state hospital who is in much worse condition than she is . . . yet they keep letting her go to live with him from board and care homes and also from the hospitals until something serious happens which is usually just a matter of days and she
ends up in the general hospital where they usually send her back to another board and care home or the state hospital. This goes on and on. There is no attempt to keep track of her . . . (letter #22)"

**Fiscal incentives for community alternatives**

We are confronted by a fiscal paradox. Welfare patients, Medicare, and Medicaid are available to discharged patients but not to hospitalized patients. Thus, there is a strong incentive for state and local governments to rid themselves of their financial obligations by emptying and closing their state hospitals. To these financial incentives are added the legal constraints in mental hospital care and the popular view, often shared by psychiatrists and other mental health professionals, that "our mental hospitals today . . . are bankrupt beyond remedy . . . and should be liquidated as rapidly as can be done in an orderly and progressive fashion." ¹⁸ Deinstitutionalization has become the goal of many state administrations.

The tragedy is that in most cases community alternatives to hospitalization are demonstrably effective if they are adequately financed and properly administered. ¹⁹, ²⁰ But there are few places in which community care has been given a proper chance. Instead, there is a growing disillusionment with community care, and the historic pendulum threatens to swing back to reliance on hospitalization and custodial care.

**Summary**

The reform movement of the 1840's took mentally ill patients out of inadequate community care and placed them in remote state hospitals. The reform movement of the 1960's shifted the mentally ill from state hospitals back into the community. Both movements were based on humanitarian concerns and backed by scientific observations. Both tried to compensate for the abuses of the alternate approach and both promised more than they could deliver. Neither was given a fair trial. The public hospitals of the nineteenth century and community care today could have delivered much better services to the mentally ill if they had received the necessary financial support. Both had to compromise their ideals to win legislative support by claiming that care in the new setting would not only be better but would cost less.

Before the pendulum swings from deinstitutionalization back to hospitalization let us see if we cannot use the lessons of the past to guide public mental health policies in a direction which combines concern for the needs of patients with regard for the needs of the community.

**REFERENCES**

2. Ibid.
4. Ibid.
8. Ibid.
9. Ibid.
10. Ibid.

* From a collection of approximately 250 letters received in reply to an insert in her column by "Dear Abby" (Mrs. Abigail Van Buren). Hereafter such references will be identified by the word "letter" and a number.
11. Ibid.
13. Ibid.
16. See citation 7.

Since 1955, there has been a steady annual decrease in the patient population of the nation’s mental hospitals.¹ The Veterans Administration Central Office reports that between 1970 and 1974, the length of stay for newly admitted “psychotic” patients dropped from 473 days to 178 days.² In 1970, 21 percent of these patients were hospitalized for more than six months; in 1974, the corresponding figure was 11 percent.

Two major trends can be discerned: (1) a drastic reduction in the number of patients residing in public mental hospitals; and (2) an increase in the number who are admitted to hospitals for short periods of time. Many patients formerly thought to require permanent hospital care have been transferred into the community and many are returned to their homes or the community after only a few weeks or months of hospitalization.

In reviewing the fate of patients who have been discharged from mental hospitals we must emphasize that post-hospital follow-up studies do not cover the total population of long-term psychiatrically disabled patients in the community. One consequence of the deinstitutionalization movement is the existence of a new and probably growing group of psychiatrically severely disabled persons who have spent most of their time in community settings and are treated in local hospitals during their acute episodes. In a recent California study, Lamb and Goertz found that only one in nine persons of the long-term community psychiatric sample requiring hos-
hospitalization had been sent to a state hospital in the preceding two years, although two-thirds had a history of state hospitalization at some time during their lifetimes. Responsibility for these numerous patients, some of whom are chronically ill and/or disabled, a few of whom are hospitalized for brief periods off and on, and others who are in various stages of recovery, has been placed on the family, the neighborhood, or the larger community. Many patients with continuing impairments are treated with large dosages of psychotropic medications. A significant number have probably drifted down the social scale following periods of acute illness, or have actively sought to live in a milieu that is less demanding and more tolerant of idiosyncratic behavior than the one in which they had originally resided. Providing proper care for long-term patients is a major public health concern.

Where do patients go after hospitalization?

Cole and his colleagues studied approximately 4,000 chronic patients who had left Boston State Hospital since the mid-1950's. Of the estimated 2,400 survivors, 500 were well enough to live at home and engage in some kind of work; 600 were in family care programs; 800 were in an apartment living project; 800 were in nursing homes; and 200 were back in the hospital.

Smaller follow-up studies have revealed that in the United States 72 percent of the discharged patients returned to a household containing a member of the family, 13 percent to live alone, and the remainder to nursing or boarding homes. Of those discharged to relatives, 50 percent lived with a spouse, 30 percent with parents, and 20 percent with other relatives. Five studies in England reported almost identical data—71 percent had returned to live with relatives and half of these with spouses.

In recent years we have witnessed experiments in the rapid mass exodus of patients from public mental hospitals in two large states for political and economic reasons. Several institutions in California were closed, and many hospitals in New York State were partially emptied. The precipitous transfers from hospitals to ill-prepared communities resulted in a kind of ghettoization. Approximately one year after the sharp reduction in California hospital census, Segal identified 11,000 former patients living in boarding homes and other residential facilities in Los Angeles. Reich and Siegel found that an estimated 25,000 chronic mental patients were living alone in one-room dwellings, class B hotels and rooming houses in New York City.

What happens to the ex-patients?

Readmission. Follow-up studies completed in the 1960's indicate that 34 percent of the patients discharged in the U.S. were readmitted within the first year, 44 percent in England. In two-to-five-year follow-up studies 57 percent in the U.S. and 48 percent in England of the patients experienced at least one readmission. Recently the number of readmissions has been rising. In 1972, 65 percent of all admissions to state and county hospitals had received prior in-patient care. These figures represented an increase of 29 percent (59,000 patients) of the annual rate over a period of three years. This phenomenon is

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probably due to trends toward briefer hospitalization, use of psychopharmacological agents, rapid discharge to community facilities for aftercare, and recurrence of the illness—especially when the patient discontinues medication and withdraws from contact with the support system.

Bachrach reviewed follow-up studies of state mental hospital patients discharged into the community to assess the mutual impact. The striking lack of comparability among the studies allowed for few conclusions. Anthony and his collaborators collected available data for 1972, and reported that in the first six months after discharge, the readmission rate was 30 to 40 percent; after one year it was 40 to 50 percent; and after three to five years it was 65 to 75 percent. These figures are thought to be reliable “base-rate data” which measure the efficacy of specific rehabilitation programs.

Though most new admissions can now return to the community, attention has been recently given to the small number of patients who do not recover. Smith and Hart compared traditional state hospital and community care in two studies and found that 10 to 15 percent of the patients continued to require some form of highly structured care and two-to-five percent remained too disturbed even to be discharged from the hospital.

Such findings indicate that responsible planning will have to include both crisis intervention centers and extended-care facilities to do justice to the various needs of chronic mental patients.

Employment. In the United States, from 16 to 50 percent of discharged patients are employed; in England, 50 percent. These percentages include women who are maintaining a home for themselves and at least one other person, as well as those who are in the labor force at least half-time. Anthony's 1972 study showed that 30 to 50 percent of patients were employed in six months after release; 20 to 30 percent in 12 months; and, 25 percent at three to five years. The following letter indicates the extent of this problem:

... I was hospitalized ... for one and a half years, and was discharged greatly improved, and, I thought, ready to take up the business of living again. I had no idea of the problems I would encounter in returning to the world! The employment problem is probably the major problem facing ex-mental patients. When I returned ... I was advised to conceal my psychiatric history from prospective employers. I preferred to be honest, but I was unable to get ... any job ... for over a year, although I applied ... where my qualifications and experience were appropriate. ... Since my work record prior to my illness had been excellent ... I was finally forced to face the tremendously discouraging fact that, as an ex-mental patient, I was not wanted. (letter #53)

Socialization. Socialization is defined differently in various studies. Consequently, it is difficult to compare the data. Brown's detailed investigation in England showed that only 20 percent of patients could be placed in the "active work and leisure" category; 25 percent did absolutely nothing. Dischargees may (1) make adequate adaptation to home and community; (2) become inadequate but tolerated residents in the community; (3) reside in local community facilities (board and care and/or nursing homes); or (4) be rehospitalized. The literature about adequate post-hospital adaptation is limited mainly to reports on readmitted patients. Socialization is variously measured by: the number of the patients' friends, by their social contact, by their attention to grooming, and by their recreational activities outside of the home. Brown and Cole mention that only 5 to 20 percent of chronic mental patients adapt acceptably to community life. Most of the remainder show significant social disability and, although some may be tolerated and sup-
ported at a low level of social performance, the majority return to the hospital.

**FACTORS INFLUENCING OUTCOME**

The rehabilitation of chronic mental patients aims at two relatively independent goals: (a) successful community tenure, i.e., the prevention of symptomatic relapse and of rehospitalization, and (b) assumption of an adequate social role, i.e., an appropriate instrumental performance in the community (vocational adjustment, including homemaking and social and interpersonal adjustment). 27

These outcome variables at first sight seem to be interrelated. For example, one would assume that faulty interpersonal adjustment would interfere with many vocational activities. Most studies revealed that rehospitalization occurs primarily as a result of exacerbations of symptoms, that inadequate instrumental performance by itself does not account for rehospitalization. 28

The degree and the quality of a patient’s adaptation depend on five groups of factors related to: (1) the patient, (2) the family, (3) the community, (4) the political system, and (5) the mental health system.

**Patient factors**

**Seriousness of the illness.** Most chronic mental patients suffer from either schizophrenic or psycho-geriatric illnesses (mainly chronic brain syndromes) of varying degrees of severity and incapacity.

For reasons as yet unclear, there is considerable variation among schizophrenic patients with respect to chronicity.

Schizophrenia has been considered by some investigators to consist of two contrasting groups of patients variously labeled nuclear or reactive; process or symptomatic; or “true” schizophrenia or schizophreniform psychosis. According to these investigators, the reactive, symptomatic, or schizophreniform group is more likely to have a favorable prognosis, a relatively good pre-morbid history, an acute onset, evident precipitating stresses, mental confusion, and no family history of schizophrenia but often a family history of affective disorder.

Other investigators reject the concept of two distinctive categories of schizophrenic psychosis. In any case, there are variations in the quantity and quality of biogenetic, psychogenic, and sociogenic factors in each patient that will influence his life course.

The rehabilitation of elderly patients so that they can stay in the community at an acceptable level of functioning depends upon many factors including: the degree of organic impairment, psychogenic symptoms such as depression or psychosis, physical illness, need for nursing care, personal financial resources and a family or other domestic group willing to provide therapeutic support. Many elderly patients suffering from acute brain disorders are admitted to hospitals and labeled as “senile.” They may not receive the proper treatment for their confusional state which would reveal that their condition is reversible. 29 The improper diagnosis and management may then be the cause of chronic impairment.

**Personality strength.** The schizophrenic patient’s handicap may reflect the extent of traumatization in early childhood and the degree of disorganization and regression in adult performance. Rehabilitation depends on the preservation—in the midst of illness—of intact personality functions. 30 Bellak has devised procedures for testing and judging “ego strength” in each of twelve areas of ego func-
tioning and has developed an ego-function profile which can be used for predicting rehabilitative success.31

Many patients, in spite of their illness, have potentially usable assets and can exercise some choices affecting their fate. Whether they become successfully or minimally adapted to extramural living or fail depends in part on their ability to: (1) exercise some control over the behavioral manifestations of their sickness; (2) resist continuing the role of patient (self-stigmatization); (3) exploit or deny themselves opportunities for secondary gain; or (4) comply with medication regimes and community care programs. One ex-patient reported:

The most difficult problem I encountered after... release from the hospital... was fighting the desire to return... The hospital is a very secure place. It protects you from others and it protects you from yourself. Although other patients complain, often bitterly, about the locked doors and the lack of freedom, they are actually terrified of being released... Becoming members of society entails responsibilities that mental patients are often afraid of and really can't handle... The hospital is a womb, it's safe... When things start closing in... there are people who understand... you, there are rooms where you can scream and beat the walls... There is medication when... you really can't take being conscious any more... Your fellow patients... understand you, and give you support, and that is sometimes most important of all. Your unhappiness is accepted in the hospital as it is not on the outside... when things start going badly on the outside, you start thinking... if only I were back... and pretty soon... it's a necessity. (letter #131)

Participation in a community care program is easier to monitor than other aspects of behavior. Generally, the large majority of discharged mental patients do not follow through on referral to a mental health center; in one-half of rehos-

pitalized patients, exacerbation of symptoms is directly related to discontinuance of anti-psychotic medication.32,33

Family factors

Since at least initially, most discharged chronic mental patients reside with relatives, the functioning of the familial social system is crucial to the patient's adjustment. The family members are the principal arbiters of the patient's community tenure and thus the primary decision makers for rehospitalization.34 Family factors which have been studied are: (a) attitudes expressed toward the patient at the time of initial hospitalization; (b) degree to which discharged patient is experienced as a family burden; (c) expectations of the patient; (d) quality and quantity of emotional interaction patterns; and (e) demographic factors, including a comparison of marital versus parental families.

Initial attitudes. Brown observed that a negative emotional response by the patient's relatives at the time of his hospitalization was significantly associated with symptomatic relapse after discharge.35 Vaughn and Leff, in a replication of the Brown study, used a rating scale for the relatives' expressed emotional attitudes (EE) critical of the patient. Of patients from high EE families, 90 percent relapsed within nine months after discharge; in contrast, the relapse rate from low EE families was 6 percent. Vaughn and Leff concluded that expressed emotional attitudes are good predictors of posthospital relapse, independent of the patient's previous behavior disturbance and work impairment.36

Family burden. The patient's negative impact on the family has been divided into "objective" and "subjective burden."37,38 The former is the demonstrable effect the patient
has on the household, as measured by an independent observer, including symptomatology, financial distress (employment), impairment of relatives' health, adverse effects on children, and disruption of social routine. All studies agree that the “objective burden” is considerable. One-third of the families have some burden, nearly one-half have a moderate burden, and one-fifth bear a severe burden. But, uniformly, investigators have expressed surprise at the adaptive tolerance of those families who do not rehospitalize their patient-member.

The “subjective burden”—the family’s estimates of duress and oppression caused by the patient’s presence in the home—is considerably less than the researchers’ objective estimate. The decision to rehospitalize usually is directly related to the family’s subjective distress stemming from intolerable symptoms. The patient’s failure in role performance (work, parenting, homemaking, recreation, social contacts) is only weakly correlated with the rehospitalization rate.

Even though the tolerance is high, so is the cost. Doll investigated 125 lower-class families who had one posthospital member. He found a remarkably high acceptance of deviant behavior—only 12 percent of the patients had been rehospitalized in the first 10 months after discharge. However, the family and the patient “paid a price” for continuing to live with each other. Family members spoke candidly about pain, bitterness, shame, antagonism and a feeling of being trapped. Most of the patients experienced physical acceptance and social rejection; they were tolerated but isolated outside the mainstream of family life.39

. . . It is so difficult returning to a family to begin with, let alone to a community and friends and neighbors . . . When I returned home . . . it was such an effort trying to live each day . . . the #1 problem is no one wants or can cope with the returning mental patient . . . At first my neighbors and friends did not visit, as is customary with physical illness. . . . I was so ashamed of my mental illness—I now speak openly about it . . . but I also feel I am no longer or ever was a mental patient. I was a very lonely person. (letter #20)

Creer and Wing interviewed eighty families who reported that they had maintained a chronically ill relative at home for two years. Their complaints could be condensed into two main categories: social withdrawal (90 percent of cases) and socially embarrassing behavior (66 percent of cases). Overactivity, compulsive talking, expression of irrational ideas and destruction of property were the most difficult to bear. Although all the informants described feelings of depression, anger, shame, anxiety and resignation, many seemed to cope realistically with the problems. One informant summarized the situation: “You can put him in a back ward for the rest of his days and then you have written him off; his life is finished. Or you can have him at home, and then you have to accept that you will have to alter your whole life. You will never be free again.”40

Family expectations. Freeman and Simmons,41 Brown,42 and recently Serban and colleagues43 have given special attention to fit or misfit between what the patient expects and what the family expects with regard to post-hospital performance. They agree that a misfit leads to rehospitalization. When both patient and family have either relatively high or relatively low expectations of performance, the patient is more apt to find the family a tolerable milieu. But when patients leave the hospital with the unspoken intent to maintain a dependent role and the spouse expects them to resume roles as husbands or wives, parents and breadwinners, disaster is a predictable outcome.

The issue is complex. The patients and their families may have relatively high hopes which are unrealistic, especially if the patients have overestimated their ability and underesti-
imated their handicaps, while the families need to believe that they have been cured. When both patient and family have very low expectations, regression and patienthood can occur to the point that bizarre symptoms reappear. “Good adjustment requires that the patient’s attitudes and expectations about his post-hospital life be consistent with the reality of his level of ability and the demands and expectations of those in his social environment.”

**Interaction patterns.** Several investigators maintain that emotional interaction patterns in the family influence the patient’s future. On the positive side, Deykin concludes that it is not always essential for the patient to achieve a good level of adjustment to remain in the community. “The more available resources the patient has in terms of family . . . supports, the less need there is for the patient to be psychiatically well.”

On the negative side, according to Goldberg, “unsettled patients live in families whose members constantly impinge on them.” Brown and his co-workers have studied high and low involvement. They conclude that highly involved families are most deleterious to a patient’s welfare because the emotional involvement is usually critical, demanding and exhortative. Patients returning to highly emotionally involved relatives are therefore more likely to suffer relapse. Both over-arousal and under-stimulation can be noxious. The optimal home environment is “structured and neutrally stimulating.”

In a comprehensive review of family responses, Kreisman and Joy recommend further investigation of patient-family relationships with a view towards interaction. “It seems likely that the important information is to be found in the interactions rather than in one or another main effect.” But the extremely complex set of interacting family variables has not been studied exhaustively.

They try to handle you with kid gloves. If you start to get angry or depressed, they say, “now don’t get upset—everything will be all right.” But a common . . . cause of depression is a person’s inability to feel and express emotions . . . they feel that, as former mental patients, you are always on the verge of another “breakdown,” and that any show of emotion means you are . . . going off the deep end again and . . . any protestations on your part . . . serve to reinforce their fears. (letter #131)

**Demographic factors.** The willingness of a family to accept and keep a patient at home is related to age, sex, race, class and family constellation. The elderly often have no family to return to, or if they do, they are frequently unwelcome because of their greater dependency needs and their inability to contribute to the family support. Women are more readily accepted than men and at a lower level of adaptation because they are not expected to join the workforce or spend much time outside the home. Black families seem more accepting than white, although they may be less adept at seeking and demanding community or hospital placement. Lower class families are more likely to cut ties with the patient with each successive hospitalization.

The incidence of rehospitalization is related to the constellation of the family to which the patient returns: spouses are “healthier” to live with than parents. The explanations for this difference vary: (a) schizophrenic patients who have a spouse to whom to return are probably less often “process” cases than those who have never married, and thus they have a better prognosis; (b) spouses generally have higher expectations of patient performance than parents and therefore urge patients to employ their maximal capabilities; (c) parents tend to re-establish the child-parent dyad and unwittingly invite regression; (d) parents who have lived through
the entire course of a patient's illness may be understanding and indulgent in order to deal with their guilt feelings.

Community Factors

Attitudes. Rabkin has made a thorough review of the extensive attempts to sample public attitudes about mental illness over the last 30 years.\textsuperscript{52} Up to 1960, studies showed uniformly that mental illness was feared and mentally ill patients were stigmatized and shunned. For example, the final report of the Joint Commission summarized society's pattern of rejection and the pervasive "defeatism" that stands in the way of effective treatment: "Several studies of public attitudes have shown a major lack of recognition of mental illness as illness and a predominant tendency toward rejection of both the mental patients and those who treat them."\textsuperscript{53}

The results of surveys made since 1960 are more varied. Encouraging reports emanate chiefly from Lemka, Crockett, Spiro and their colleagues in the Baltimore area.\textsuperscript{34, 55, 56} They found that the general public is: (1) better informed about mental illness;\textsuperscript{57} (2) more convinced that it is a form of illness and like any other should be so regarded; and (3) more tolerant of the mentally ill living in the community. But other studies during the same decade in different communities indicate that the mentally ill are still heavily stigmatized, feared and held at a distance.\textsuperscript{56, 59} Although respondents to questionnaires expressed more understanding and tolerance, social distance from mentally ill persons is still the prevailing stance. A definite feeling lingers that physical illness is quite different from mental illness and there is widespread doubt that mental illness can be cured. One ex-patient reported:

My real problem was when I started working. I never knew how much people liked to talk about mental patients. I heard the most childish assumptions expressed as gospel truth.

None of my co-workers knew that I had been a mental patient, and I . . . made up my mind that I should never want it to get out . . . I became aware of what former mental patients must suffer . . . They become convenient scapegoat(s) . . . People who return from state institutions have to fight terrible prejudice . . . trying to make a comeback. (letter #37)

Another ex-patient's relative wrote:

. . . My younger brother . . . has been in and out of hospitals . . . for ten years . . . 90 percent of the time, as long as he stays on his medicine, he is as normal and rational as anyone else . . . The gossipsness of a small rural community can be extremely cruel. All the relatives have simply stopped visiting and talking about him to us . . . no one . . . even mentions his name. He isn't dead; he is just a sick person needing help. (letter #58)

Rabkin's summary of 18 surveys of the characteristics of mentally ill patients that influence public attitudes indicates that labeling is critically important. "The public apparently is willing to regard as normal a much broader range of behavior than experts would . . . define, as long as the behavior is not labeled a manifestation of mental illness."\textsuperscript{60} The public gives a negative value to three characteristics of the defined mentally ill: unpredictability, dangerousness, and lack of personal accountability. They think that the mentally ill cannot be trusted to behave and that no community agency can be depended on to accept responsibility for them.

The public rejects visible socially disturbing behavior while some manifestations of mental illness that alert professionals (schizophrenic withdrawal, depression, autism) are tolerated or not recognized. "If investigators wish to maximize public aversion to a case description, the person would be described as male, lower class, probably black, violent, hearing voices, showing bizarre behavior, and lacking social ties within the community."\textsuperscript{61}
Mental health professionals have often contended that mental patients are neither dangerous nor to be feared and that the public’s apprehension of the mentally ill is unfounded. They base their views on studies of arrest records which fail to show higher crime rates among ex-mental patients than among the general population, and on the clinical experience that the great majority of professionals have never been injured by people they treat.

However, recent studies indicate that psychiatric patients are more often arrested for violent crimes than corresponding members of the general community. Lagos and his associates found that 36 percent of 321 hospital admissions were preceded by some manifestation of fright inducing, threatening, or violent behavior. To limit their sample to mentally ill patients they excluded those who were diagnosed as personality disorders or as drug and/or alcohol dependent. Based on their findings they assert that the public’s fear of the mentally ill is not unfounded but they believe that people fear mental patients “too much, under the wrong circumstances, or for the wrong reasons.”

Such community fear presents a serious problem because it increases exclusionary actions against the mentally ill by people who would not tolerate in their neighborhood anyone deviating in any way from the norms of behavior or appearance.

The time honored process of managing disturbed and disturbing citizens by exclusion from the community is not dead. Aviram and Segal describe several techniques used defensively by communities to exclude ex-patients: shunting them into jails, prisons, and ghettos; blocking their entrance into the functioning community; passing restrictive ordinances and regulations; and other inventive bureaucratic maneuvers such as playing the “zoning ordinance game” described by Cupiauolo.

Given a choice, the community seems to favor hospitalization. Rachlin and his colleagues report the attitudes of families and the general community toward a locked psychiatric ward in a community hospital which overtly deprived the patients of freedom and by its operations ignored some of their civil rights. The community strongly favored the facility; during the two-year study not one protest was received from patients’ families or the community at large. Instead, the unit was deluged with families’ requests for admission of a relative. The major public relations problem facing ward personnel was the task of persuading the community and/or family that a particular patient was ready for discharge.

**Community settings.** A dual standard for mental health care is firmly established in this country. The electorate is reluctant to contribute to psychiatric care in general and is even more resistant to the provision of adequate care for the public patient. In public mental hospitals there are 106 professional staff workers per 1,000 patients; in private psychiatric hospitals 502; and in psychiatric units in general hospitals 420. The community standard of care is scarcely better. Rachlin points out that “the previously involuntarily hospitalized have now been involuntarily communitized,” and the social and mental health services in the community are often less adequate than in the public hospitals.

For a long time the state hospitals were the last resort of the socially dependent mentally ill who had neither families nor friends able or willing to support them. Recent federal welfare legislation made the mentally disabled eligible for monthly income maintenance and Medicaid or Medicare. They became sources of revenue for entrepreneurs willing to provide residential care. In a short time a veritable “industry” of sheltered care facilities developed for socially dependent people who required nonmedical care. Many attendants, nurses or aides who wanted to go into business for
themselves saw an opportunity to remodel old residences into board and care homes. Others found that they could supplement their incomes by opening their homes to patients released from hospitals. Owners of old hotels catering to the aged and transient or owners of boarding homes catering to college students, recognized the new market for their facilities. Many if not most of these providers of housing had neither the interest nor the capacity to provide activity and rehabilitation programs as well.

The individual patient’s need varies with his dangerousness to others or to himself, his dependency and his potential for growth.

A spectrum of domiciliary settings extending from institutions to independent living arrangements is required to meet ex-patients’ needs. These include the following, listed in order of decreasing protection for the patient and increased autonomy:

1. “Skilled nursing facilities,” also known as “therapeutic residential centers,” are 24-hour, intensively supervised, community-based facilities. They can serve as alternatives to state hospitalization and offer the advantage of providing more interaction and individual attention. They permit the maintenance of social ties to families and friends, and support the expectation that patients will be able to move to more independent living situations. They may serve as temporary placements in lieu of hospitalization for chronic patients suffering an acute exacerbation, or for people living in residential care facilities suffering a severe crisis. The availability of such facilities, strengthened by a mental health team supported by public funds, has enabled some California counties to reduce considerably, referrals to state hospitals.

2. “Intermediate care facilities” or “community treatment houses” provide 24-hour intensive treatment, skilled nursing care and supervision on a temporary basis in a home-like setting, usually a converted residence. They, too, prepare patients for transition to family life or domiciliary care programs.

3. “Halfway houses” are intended to help people impaired by mental illness to resume participation in community life through a process of gradual resocialization. They also provide a place to stay until a suitable residence becomes available.

4. “Residential facilities” or “residential care homes” are family homes or group homes, often referred to as “board and care homes,” which supply services to adults or children requiring care and supervision. While they are located “in the community,” their residents may be as isolated from actual participation in ordinary activities as they were during hospitalization. The better homes have social activities programs.

5. “Social rehabilitation facilities” are residential facilities which supply 24-hour services to persons who temporarily need assistance, guidance and counseling. These persons are expected to live by themselves.

6. “Satellite housing” includes apartments, duplexes or small single family dwellings for former patients without live-in staff but with some professional guidance, supervision, access to counseling and assistance for emergencies. They are much less expensive than halfway houses because there is no round-the-clock staffing. The residents share the shopping, cooking and maintenance tasks. All residents, unless specifically assigned to take care of the family style home, spend all or part of their day outside their dwelling in employment, in friendship centers, day treatment centers, vocational rehabilitation programs, or sheltered workshops. They may receive some form of therapy outside the residence. Satellite housing can accommodate large numbers of chronic patients and ex-patients for long time periods at reasonable cost. The goal is to help residents to become able to deal with the
normal demands of life by themselves and learn to work and play as comfortably as possible.

7. A variant of satellite housing is the "landlord-supervised cooperative apartment program," a hybrid of foster family care and independent apartment living. The landlord provides some supervision while respecting the resident's privacy and independency. The landlord's willingness to be available to the tenants eliminates the resistance of neighbors which so often hampers community housing projects for ex-mental patients. Another variant is the "Fairweather Lodge," a subsocietal arrangement similar to Synanon for ex-drug users, completely organized and operated by the patients themselves with only occasional visits by staff members.

8. The Missouri Foster Community Program is patterned after the Gheel Colony in Belgium. It provides full community integration of former patients who, after a period of time, participate in all community activities as fully as other citizens.

When large numbers of mental patients from state hospitals were first released into the communities, many people feared that residential facilities would depreciate adjacent real estate values and/or that these "raving manics" would make their neighborhoods unsafe. Government agencies in cities and counties used zoning restrictions and other ordinances to prevent the establishment of care facilities in certain residential areas. In other areas, "mental health ghettos" were created. In some cities, as many as 500 mentally disabled persons live in large, dilapidated, old residential hotels in a circumscribed area.

Residential care homes are a private business; the administrators expect a profit from their investment and effort. Many mean well and also derive psychological satisfaction from their caretaking activities. However, many lack proper guidance and understanding. Their low expectations of the ex-patient encourage passivity and dependency, thus countering the intent of the community mental health movement to return the patient to the community. Caretakers often do not allow their boarders to participate in daily chores. Consequently, many residents spend their days in boredom, daydreaming, or watching television; this passivity, isolation and inactivity create the depressing atmosphere described repeatedly by graduates of board and care homes.

The boarding homes are . . . old, run-down houses in districts that are the same . . . For the residents there is nothing to do but stay in their crowded rooms or stare at each other . . . There is no supervision, no effort to have them take their medications, no attempt to keep them busy with arts and crafts, or reading or group recreation . . . They live with drug addicts, alcoholics, ex-convicts, and elderly people whose only crime is getting old. (letter #22)

Residential care homes represent by far the largest placement resource for deinstitutionalized patients. At worst, these homes combine the isolating and alienating features of a back ward in a state hospital. Edelson showed that: "Without adequate treatment and rehabilitation programs, community living may be as institutionalizing as the worst state hospital." A California study based on interviews with 499 ex-patients between the ages of 18 and 65 and the operators of the 234 facilities in which they lived, uncovered five issues of major importance:

1. Stigmatization. Sixty-eight percent of the facilities served not only the mentally ill but other groups such as alcoholics, mentally retarded, dependent-aged, and transients. "As a general policy such care represents a return to the poorhouse approach, emphasizing aggregate care for all those unable to 'make it' in our society." This limits the application of specific helping strategies to specific groups and a new negative stereotype, the designation "totally disabled," is added to the label "mental illness."
2. Helplessness. The residents often proved to be socially and psychologically handicapped. Many were unresponsive to the efforts of the frustrated workers to integrate them into society since they had never been habilitated in the first place. A selective use of the rehabilitation model and an emphasis on prevention of further deterioration was seldom in evidence.

3. Isolation. Sheltered care facilities were usually excluded from residential zones because of fear that the presence of ex-mental patients would depress property values and increase the rates of violence and crime. These may be rationalizations to cover the underlying community fear of the mentally ill. The conflict between the communities' rights to protection and the released patients' civil liberties is an unresolved issue.

4. Access to treatment. The degree of psychological disturbance raised the issue of "the right to treatment," and whether treatment was an institutional or a community responsibility. This issue is complicated by tightened budgets and growing competition between hospitals and community facilities for available resources.

5. Quality assurance. Monitoring the quality of care in the sheltered care facility remains a difficult problem; most residents see themselves dependent on facility operators and other service providers and feel powerless to effect decisions. Patient organizations and resident advocates must be available to insure higher quality of care.  

Shadoan demonstrated that board and care homes can be therapeutic. A high-expectation atmosphere in residential facilities greatly enhances their rehabilitative potential. As the first step, he suggests organizing a weekly home meeting to encourage a spirit of cohesiveness, give residents an opportunity to discuss individual and group problems, and express conflicts and grievances as an alternative to withdrawal, resignation, or acting out. He also recommends that residents be given responsibilities in the management of the facility; these include specific chores, maintenance of buildings and grounds and the handling of mail. Residents should be seen by the staff as potentially self-sufficient and should be encouraged to participate as much as possible in events outside the home. The home should be linked with a community care program whose staff can monitor each patient's progress.

Volunteers can reduce the atmosphere of isolation. Local mental health associations can sponsor projects such as "friendship clubs" to bring long-term patients, ex-patients and non-patients together. The opportunity for residents of care facilities to interact with regular members of the community helps them to acquire the social competence that is necessary for fuller integration into the community.

The inadequacy of community care as an alternative to hospitalization was dramatically demonstrated by a class action lawsuit brought against St. Elizabeth's Hospital in Washington, D.C. The charge was the unnecessary retention of a group of patients who could be discharged if adequate community facilities were available. The suit was directed against the community for not providing less restrictive alternatives to hospitalization. Ruling for the plaintiffs, the Federal judge ordered the District to provide alternatives such as a sufficient quantity and quality of halfway houses, sheltered workshops, nursing homes and day care centers. Unfortunately, it is not in the power of the Court to furnish the funds for such projects.

The political factors

Following on the heels of several Federal Court decisions, state legislatures are moving rapidly to revise commitment laws, protect prospective patients' civil liberties, and severely limit involuntary admission to mental hospitals. These statu-
tory changes, based on such landmark legal decisions as *Rouse vs. Cameron, * Lake vs. Cameron, * Wyatt vs. Stickney, * Donaldson vs. O'Connor, * and Dixon vs. Weinberger, * have contributed to swelling the ranks of chronic mental patients in the community. * Following the early enthusiasm, high expectations and unpredicted consequences which commonly attend new ventures, the process of deinstitutionalization is undergoing critical reassessment. Papers on “Dismantling the Mental Hospital,” * “The Case for the State Mental Hospital,” * “The Future Role of the State Hospital,” * “The Case for Involuntary Hospitalization of the Mentally Ill,” * describe the current controversy. Most of the recent literature points to an interest in reassessing the role of the mental hospital as an integral part of a total care system. One possibility for developing effective services for the long-term patients is to restructure and reorient public mental hospitals to fit current social values and community needs. Eaton has outlined a practical scheme by which the hospital and its extended services can provide true continuity of care by a staff believing in and committed to long-term patients. * The report of the General Accounting Office (GAO) on deinstitutionalization recommends clarification of standards and conditions for the treatment of persons in institutions or in the community. * In a similar vein, a recent HEW report states that before mental hospitals can be supplanted, there must be a thorough understanding of the functions which they serve in American life and a consensus as to which of these functions should be continued or discontinued. * In the private sector of mental health practice, the private hospital, the psychiatric unit of the general hospital and the practitioner’s office are established components in a subsystem of care. As far as we can determine there has been no movement to close private psychiatric hospitals. However, the length of stay in private hospitals is almost completely determined by the limits on third-party payor insurance coverage. Public hospitals have no arbitrary limit set by the current economic system. In some states rate-setting commis-
ions have begun to question the charging of full hospital fees for patients hospitalized beyond set periods. Some psychiatrists consider this kind of governmental budget pressure the private hospital equivalent of the deinstitutionalization movement in public hospitals.97

There are many piecemeal descriptions in the literature indicating that acutely psychotic patients can be managed in community mental health centers rather than in hospitals to the financial advantage of the community and with social and psychological advantages for the patient. But these conclusions do not apply to the chronic mental patients who are the concern of this report.98 "Local officials and community mental health professionals find it difficult to accept the idea that their area of responsibility includes these chronic, difficult-to-manage patients. Considering the picture as a whole, it is hard to avoid an uneasy suspicion that professional zealotry and political drives for economy have preempted thoughtful assessment of the psychological needs of psychotic patients and of their friends, neighbors and relatives."99

Community care services are one of the main issues involved with deinstitutionalization and reintegration. In general, they have not been available to engage patients in community re-entry. Without outreach, "many released patients do not have the physical or economic means, the motivation, or understanding to seek needed help. The result is often a social or emotional crisis, resulting in rehospitalization. The rate of readmission may reach as high as 60 percent."100

Another major issue relates to the priorities and capabilities of the community mental health centers. In Indiana, Gunderson et al. found that only 35 percent of all schizophrenic patients who registered at an out-patient facility actually received any treatment.101 Over half of the remaining 65 percent received nothing more than intake services or a diagnostic evaluation; and another 13 percent received only psychological testing with no follow up. About half of the 35 percent who began out-patient treatment abandoned it. The authors assume that the high readmission rate reflects the reluctance or inability to provide meaningful treatment for chronic patients in out-patient facilities. "The traditional orthodox out-patient model is inappropriate for schizophrenic patients, based, as it is, on the naive proposition that these patients and their families should be cooperative and eager to come in for treatment."102

After surveying the California situation, Lamb concluded that community mental health programs tend to exclude long-term patients.103 Emphasis is on intensive care programs and crisis intervention. Overtly or covertly, priority is given to patients presenting a "favorable" prognosis, high motivation, an intact family and illness of recent onset. Even where there is less stress on brief treatment, professionals and community mental health centers favor bright, verbal, usually well-educated persons for long-term treatment. They justify their attitude by the claim that this group stands to gain most from individual and group psychotherapy. Thus, for a variety of reasons, the vast majority of long-term schizophrenic patients are excluded from community programs.104,105,106,107 Inadequate referral procedures, specifically the lack of involvement on the part of the referring professional, are the single most important factor in the exclusion process. Rogawski and Edmundson found that the success of referral depends chiefly on the interest and involvement of the referring professional and that characteristics of the patient and distance from the community resource had no significant effect.108

It seems agreed that extramural management of seriously ill patients is difficult and often frustrating, particularly if the professional's frame of reference is the traditional psychiatric out-patient treatment model. Linkage can be accomplished, however, and is helpful to the patients. Winston et
al. demonstrated that schizophrenic patients hooked into a community care program had a significantly lower rate of readmission than a matched group receiving no treatment. Of 114 patients referred, 78 percent followed recommendations. The patients were transferred to a mental health center operated by the hospital, facilitating continuity of care. Most of the patients received the sustained attention of their hospital therapists.

A similar arrangement, called a "mini-mental-health-center in the hospital," has had comparable results. "If he needs community care, we discharge him to ourselves." The hospital staff administers board and care homes and a day care program and conducts family group meetings and home visits in addition to psychotherapy and drug supervision.

In an effort to develop a group of effective and interested workers for a community care program, one state hospital offered its mental health technicians an optional training experience which would qualify them to supervise management of chronic mental patients in the community. Many of the personnel elected to change jobs; they graduated from training and began working with post-hospital patients, their families and workers in related services such as welfare, rehabilitation and public health. A follow-up study two years later demonstrated that the community care service was working well, that 90 percent of the trainees were still on the supervisory job, and that the rehospitalization rates of patients they served had been reduced.

Success, however, is not certain. A similar effort to convert hospital personnel to community care specialists was less successful, in spite of a well-conceived training program. A follow-up study one year later disclosed that 53 percent of the workers had remained in the structure and comfort of hospital practice. One difference between the two programs was that in the first, portions of the entire hospital staff, including psychiatrists, psychologists, social workers and nurses had moved into the community mental health center along with the technicians. In the second, the technicians were offered placement in centers with unknown staff which required a much greater adjustment, not only to new functions but also to new working conditions.

The literature of the last two or three years is replete with positive descriptions of halfway houses, day hospital programs, day care centers, transitional care services, sheltered workshops, welfare hotels, apartment living projects, drug clinics, resocialization training groups, foster homes, structured home visits, consultation services to nursing and board and care homes, and patient advocates or ombudsmen. Characteristically each report ends with the statement that "evaluation of the program is in progress." However, one gains the impression that much experimental work is going on, and that we possess a host of techniques for improving our present poor record in providing community care services—if we have the will.

The Louisville Home Care Study, a unique research project of Pasamanick, Scarpetti and Dinitz, demonstrated that chronic patients can be maintained successfully in their homes if their families are given adequate counsel, enlightenment and repeated support by mental health professionals. But routine out-patient care by community agencies alone could not or did not achieve the same success. One hundred and fifty-two schizophrenic patients referred for hospitalization were evaluated. Fifty-four were admitted to the state hospital and 57 were kept at home with adequate psychotropic medication and scheduled visits by public health nurses who conferred regularly with their teams' psychiatrists and social workers. Forty-one patients were accorded exactly the same management as the home group of 57 except that a placebo was substituted for active medication. After three years the program terminated; 77 percent
of the home-drug patients were still at home in contrast to 34 percent of the home-placebo group. The 54 patients hospitalized at the beginning of the project had all been discharged. Their readmission rate was greater than the first admission rate for either of the other two groups. The group of 57 home-drug patients had better ratings also on mental status, psychological test performance, domestic functioning and social participation than the other two groups. When the project ended in 1964, all the patients were referred to appropriate community agencies, usually psychiatric outpatient departments. Evaluation five years later disclosed that the home-drug group had lost all of its advantages, and that members of the three groups were indistinguishable in terms of the number of days hospitalized and in social performance. “The most important finding of the study was that chronic schizophrenics, in order to remain successfully in the community, must have continuous supervision and medication. They and their families must receive social services and emotional support to alleviate the all-too-familiar pattern of personal and family disorganization.”

The authors express concern, if not bewilderment, that their research findings, awarded national prizes and wide publicity, have had no observable impact on current community mental health practice.

Unfortunately, and contrary to common belief the broad array of coordinated community services that is necessary if former patients are to be supported, sustained and helped simply does not exist. It also seems essential that one agency accept the responsibility for the coordination of services to each individual and his family.

For most chronic mental patients community rather than public hospital residence is both feasible and desirable, if psychiatric professionals will take interest in them and responsibility for them, and if communities will accept responsibility for financing their care. As Ozarin points out, the Federal Amendments of 1975 charged the community mental health centers with the responsibility for making all these services available and effective. They must assume a leadership role. Will they? There are even indications that some centers, close to the end of the 8-year federal funding period, may forego further federal assistance to free themselves from the onus of having to care for the chronic patient. Is this a sign that the pendulum is swinging back and that we are about to “discover” that chronic mental patients should return to state institutions “for their own good”?

Parallels with the past
In the first three sections of this report, we have reviewed the history and the current state of deinstitutionalization. Before going on to a discussion of relevant issues and to some specific recommendations for the future, we shall try to predict in a few paragraphs what may happen if the lessons of the past are ignored. These predictions are based on some striking parallels between the situation today and the situation a hundred years ago when humanistic interpersonal treatment and therapeutic institutional care began to decline. The parallels can be found in psychiatric ideology and education, in the science and technology of psychiatry, and in its politics and economics.

For example, the ideological emphasis then on the interpersonal and humanistic understanding of the mentally ill was replaced by an emphasis on cellular and brain pathology and on classification of mental illness. Now, the humanistic concern for mental patients, which reappeared in the middle years of this century, is endangered by preoccupation with advances in psychobiology and psychopharmacology.

Educationally, the inspired leaders of moral treatment failed then to train successors to counteract the pessimistic view of mental illness that evolved with the development of
scientific medicine. Now, the pioneers in community care have failed to train new leaders and new clinician-administrators prepared to accept the responsibility for the formulation of new policies and for the development and operation of community programs for psychiatric rehabilitation.

Culturally, the advocates of moral treatment, dependent on familiar interpersonal relationships, were not prepared then to adapt their treatment approach to the mentally ill members of a mass of immigrants who differed in language, socioeconomic status, and education. Now, the advocates of community care, also dependent on familiar types of interpersonal relationships, have not sufficiently adapted their treatment approach to the growing demands of new consumer groups, recent migrants from a broad range of ethnic and cultural backgrounds and people such as drug abusers who have been diverted from the correctional system.

Then, the locus of segregation of the mentally ill was shifting from jails and almshouses to state hospitals away from our communities. Now, the locus of segregation is again shifting, this time from state hospitals to ghettos and residential care facilities still isolated from our communities.

Then, rising costs and financial distress caused cutbacks in hospital services and virtually made moral treatment impossible to carry out. Now, recession and inflation have led to cutbacks in community care that have made its ambitious goals virtually impossible to attain.

These parallels are disturbing and suggest that history may be repeating itself, that the hope that the chronic mentally ill in this country will be rehabilitated or at least given humane and dignified care is being abandoned, and that they are doomed either to return to custodial institutional care or to drift, rejected and unattended, in the back-waters of our cities.

But the situation, although critical, is not yet hopeless. The trend to close state hospitals and dump their chronic patients on unprepared communities has been slowed for various reasons. There is still evidence of interest and concern for the chronic mentally ill among some professional and lay groups and individuals. There is still time to revitalize old programs and to start new ones that will provide progressive, responsible, comprehensive and integrated community care.

What can psychiatrists do? What can other mental health professionals do? What can legislators, public officials, mental health associations and the public do?

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ISSUES AND DIRECTIONS

Many problems lend themselves to analysis and to potential reasonable solutions, but vagaries on priorities, in initiatives and in durability of investment result in uneven accomplishments. So it is in the area of deinstitutionalization and community care. We have had the opportunity to learn from experience and this has tempered our expectations. We have been able to recognize the dysfunctional elements of the deinstitutionalization movement as well as its strengths. Our position is moderate yet comprehensive.1 Given a high priority, a vigorous initiative, and consistent human and material investment, the major goals of the deinstitutionalization movement can still be implemented. But whether they will be implemented depends upon developments in (1) ideology and education; (2) science and technology; and (3) politics and economics.

Ideology and education

Psychiatrists in the community care field. Although some psychiatrists were among the leaders in the community mental health movement, their involvement has gradually diminished.2 Rapidly increasing service demands coupled with inadequate psychiatric manpower resources, soon brought social workers, psychologists, and others into administrative roles as well as into more significant clinical responsibilities. A mental health industry was born; its organization, priorities, and technology were shaped by new coalitions which changed the role of psychiatrists and reduced their control over policies and their authority when compared to the power previously exercised by superintendents of public mental hospitals.

Even if leadership responsibilities in community care could be returned to psychiatrists, should they be? What is the proper role for the psychiatrist in community care? To be responsible for the development of new ways of treating the mentally ill is far from being responsible for large-scale alternate living designs. The psychiatrist is familiar with traditional role functions: patient evaluation, individual psychopharmacology, milieu care, and consultations to families and other social support systems. But he is not trained for working with complex multi-agency community care technology and is uncomfortable in such roles. Therefore, if psychiatrists are to strengthen or even to maintain their legitimate clinical and programmatic roles in community care, there must be a change in their attitudes toward deinstitutionalization as well as in their training.

Training in community care. This committee does not believe that all community care, including aftercare programs should be dominated by psychiatrists.

It does believe that primary responsibility for medical management of the chronic mental patient in the community rests with the psychiatrist. In other words, when the clinical or medical model is the appropriate frame of reference within which to understand the patient’s personal and interpersonal handicaps, the psychiatrist is the natural leader of the team as it attempts to help the patient and his family.

The clinical or medical model is not the only frame of reference, however, for understanding the discharged patient. To the extent that the chronic mental patient and his family need social rehabilitation services, including help with housing, education, employment, grooming, deportment and other socialization skills, the psychiatrist’s contributions...
can best be made as a member of or consultant to the rehabilitation team rather than necessarily as its leader.

Thus, the committee believes that psychiatrists should have a major role in the provision of community care. To do so, most residency programs will have to be modified. They are already stressing psychopharmacology, an essential element of the treatment for many ex-hospital patients, and some community mental health issues are included in formal curricula. But in most programs there is little, if any, specific instruction in agency consultation, in principles of socialization and rehabilitation, in the design and functions of health delivery organizations and in linkage technology.

There are a few exceptions. For example, one innovative course focuses on the technological implications of new service patterns, including topics such as:

- design of residential and partial care services
- service designs to provide continuity in a complex system
- special service designs for migrants, for older people and for users of intermittent and prolonged care
- techniques for enhancing affiliative capacity in isolated persons
- the role of home visiting nurses as service agents
- applications of the biology and epidemiology of schizophrenia to community care service design
- review of health and welfare programs operating in local school, industrial and residential settings
- consultation practices in various agency settings

We hold that psychiatric residents most likely to maintain involvement and to make contributions to the community care field will be graduates of training programs that have important linkages with community mental health centers and with state hospitals and faculty members who serve as models such as practitioner-scholars who have interest and experience in community care and encourage a continuing involvement in community care activities.

The separation of in-patient and out-patient assignments in most psychiatric residency programs interferes with the residents' observations of patients over time and with their becoming acquainted realistically with the problems of achieving continuity of care. At least part of each resident's time should be committed to the uninterrupted responsibility for a selected number of chronically ill patients. Residents should be encouraged to leave the office or the ward to meet with patients in family, vocational and social settings to gain a better understanding of the problems and tasks confronting the long-term mentally disabled person.

As is true of other branches of medicine, psychiatric residents will be influenced mainly by the role model set by teachers. It is important, therefore, that training programs have practitioner-scholars on their faculties who can elicit respect, who have interest and experience in community care, and encourage a continuing involvement in community care activities.

Shifts in educational directions have always been partially stimulated priorities established by funding bodies. As national needs are identified and articulated, it is reasonable to expect that funding agencies, acting on behalf of the public, will build incentives calculated to meet those needs. The entire community mental health movement was an expression of this process but the education of psychiatrists has changed only in part; education in deinstitutionalization and community care has not been significantly influenced.

Any residency program receiving federal training support could be required to offer explicit curricular and practical community care experiences that equip psychiatrists with needed skills and knowledge. In this way, future residency training programs receiving public funds can produce psychiatrists well trained to meet the public's need for com-
munity care. Only with the development of such professionals can psychiatry participate in a significant way in the care of a patient group that is one of its primary responsibilities.

Many practicing psychiatrists probably cannot be enticed to become more involved in the community care field. Their attitudes were shaped by training experiences of the past. But it is reasonable to encourage the development of continuing education programs to inform interested practitioners of the new knowledge in the community care area. Residency training programs that are directly involved in community psychiatry education, and particularly in its community care aspect, can develop and maintain such continuing education programs.

Science and technology

Although medication is usually viewed as an essential ingredient of community care, the impetus towards deinstitutionalization resulted not only from the new phenothiazine drugs, but from the organizational and system technologies developed within the community mental health movement. To meet the needs for comprehensiveness and continuity, the community mental health industry forged new patterns of patient evaluation and rehabilitation, including halfway houses, day and night programs, resocialization and rehabilitation programs. These developments, occurring in a favorable socioeconomic and political climate, accentuated the deinstitutionalization trends that had been developing since the mid-50's. A considerable number of psychiatrists joined the leaders of the community mental health movement and developed its treatment and organizational technologies; they must take both the credit and blame for these trends. But once unleashed, the pressures for deinstitutionalization could not be met either by the traditional or by the new resources.

An epiphenomenon of the community mental health movement was the proliferation of an "organization technology" involving group orientations (family therapy, group therapy, milieu therapy), increased partial hospitalization, organized out-reach with population-based accountability, mental health team developments, institutionally focused consultative programs and prevention-oriented education programs. Together, psychopharmacology and organization technology provided the scientific and technologic base for deinstitutionalization.

There are successful deinstitutionalization programs in some states, but dehumanized, discontinuous and inadequate programs persist in many others. The troubles of deinstitutionalization cannot be attributed to insufficient knowledge. Although we do not know how to prevent schizophrenia and the major affective psychoses, although our current pharmacologic agents are not considered curative, and although our organization technology needs refinement—deinstitutionalization can work well. It has seemed to work well in Sacramento, California, as Langsley and his associates reported. A new mental health law, a new medical school interested in community mental health and a supportive community conjoined to produce programs and experiences that could be replicated elsewhere in the nation.

The Langsley group consider certain principles and practices critical for a successful deinstitutionalization program: (1) commitment to serving the needs of all patients; (2) accessibility of services; (3) a multi-disciplinary mental health team; (4) a continuum of specialized services for the chronically ill; (5) aggressive and continuous follow-up; (6) ongoing professional education; (7) public education and information; and (8) program evaluation.

This program fulfilled the twin requirements of organization technology: comprehensiveness and continuity. Too many other deinstitutionalization programs are either non-
comprehensive or discontinuous or both. They are not failures of science or technology, but rather failures of implementation or of caregiving ideology and motivation, or of ignorance of the nature of human service networks.

An example of how a multiphasic rehabilitation program improved the community care of severely disabled mental patients and yet proved economically sound was described by Barten. His multiphasic program reduced rehospitalization by more than 80 percent and cut the cost of care for each patient to 600 dollars.

Thus, the tools for making deinstitutionalization work are available. As we have indicated there are specific assessment and adjustment instruments that can be used with chronic mental patients to identify which services are needed and what kind of habilitative and rehabilitative support is required. There are studies that can predict how a family will tolerate a returned patient. There are alternative residential models varying from day programs through board and care homes to independent living homes. There are well developed crisis intervention programs, often including mobile services, that prevent unnecessary reinstitutionalization. Adequate educational, ideological and economic sanctions can make it possible for these resources to alter dramatically the condition of the chronically ill mental patients, who at present are caught between the Scylla of anachronistic state hospitals and the Charybdis of a disorganized and underfinanced community care system.

We need an orderly accumulation, synthesis, and dissemination of the scientific and technologic bases for deinstitutionalization and community care of the mental patient. Data banks, located in the National Institute of Mental Health and in other components of the Department of Health, Education and Welfare, as well as in academic centers, can provide the kind of information that would enhance the planning process substantially. As the conditions for successful deinstitutionalization develop in various parts of the country, these data would supply the information needed to implement rational deinstitutionalization procedures. They would be particularly useful to state governments and their associated mental health bureaucracies who do not yet grasp the enormous implications and requirements of deinstitutionalization.

We can also learn from the experience of other countries that have established operational comprehensive care models. Gittelman reviewed the organization of mental health services in several European countries that employ the principle of sectorized care similar to our concept of the comprehensive community mental health center. In this model, the entire care of a specific patient throughout all stages of his illness—and between periods of active symptomatology—is entrusted to a single treatment team. Often this team is based in a mental hospital which carries the responsibility of the mental health needs of the population in a defined geographic area. The team provides community care for patients leaving the hospital and continues outpatient treatment to prevent rehospitalization. The same team, if not the same doctor, treats the patient in his home community, works with all of the psychiatric facilities in the “sector,” arranges for rehabilitation, consults with halfway houses, and engages in whatever activities might be in the patient’s interest.

The availability of simplified funding, with all treatment paid for by national health services or by a system of social security is a major reason why such designs can be successful in some European countries. Since it seems likely that the United States will develop a comprehensive national healthcare system within the next few years, we should plan now for the inclusion of mental health services for the long-term mental patient in the community in the overall design.
POLITICS AND ECONOMICS

Political factors

Langsley recognized that "changes in human services are not accomplished simply by scientific fact. They also depend upon the economy and the political scene." In a system dedicated to free enterprise and the open market, services judged "necessary" or "desirable" but which do not lend themselves to market dynamics require legislative and governmental support. We depend upon the government to make sure that our schools are maintained, our fires put out, our garbage disposed of, our criminals sequestered and our developmentally disabled and chronic mentally ill cared for.

The political process ultimately establishes the levels of funding for the schools, the police, or the care of the mentally ill. The political process is responsive only to public power—expressed at the ballot box—and so the "will of the people" is the most potent motivator of government and its bureaucratic machinery. Meanwhile, the same competitive spirit that fuels our private economic system introduces into the political process competing priorities that are often difficult to resolve.

It is an embarrassing political reality that the apathetic electorate becomes aroused and exerts pressure on its representatives to remedy existing deficiencies only after some newspaper report of a scandalous incident has brought neglect of patients and intolerable conditions in the care system to the public's attention. In calmer periods, between sensational reports, funding and interest seem to dry up and legislators turn a deaf ear to requests by professionals.

Because all governmentally supported service programs are politicized, their relative priorities are established by the degree to which the public commits itself to an advocacy position. In the case of the chronic mentally ill, the public has never expressed any sustained advocacy. Priority items over time have always been those which directly affect the majority of the public or a vigorous and articulate minority. Chronically ill mental patients are neither a majority nor able to mount a vigorous and articulate argument on their own behalf.

Occasionally gifted ex-patients emerge who, in the proud tradition of Clifford Beers, arouse the attention and engage the support of public-minded citizens for the cause of the mentally ill. Priscilla Allen, a former California State Hospital patient for two years, and later a board and care home resident, has become a forceful writer and speaker on mental health issues. She has served as consultant to agencies such as NIMH and the California Association for Mental Health and she has been appointed to the President's Commission on Mental Health.

In July 1973, she testified before the California Senate Select Committee on Proposed Phased-out of State Hospital Services. At that time she recommended improved professional staffing and employment of volunteers in residential facilities to prevent the institutionalizing of residents. Eventually she became aware that merely insisting on the right to treatment was inadequate because treatment itself could create a new set of problems. Therefore, in March 1974, she authored "A Bill of Consumer, Tenant, and Human Rights for Citizens Using Outpatient Mental Health Services," that she hopes will become the basis for legislation regulating the rights of any consumer of public or private mental health services living in the community.

The rights proposed are:

- The Right to Voluntary Treatment and/or Services
- The Right to Refuse Treatment and/or Services
• The Right to Confidentiality of Personal Records
• The Right to Utilize Fully All Economic Rights and Benefits
• The Right to a Humane, Psychological and Physical Environment
• The Right to Maximum Freedom, Mobility and Independence
• The Right to Information

It falls to advocacy groups such as the Mental Health Association, the American Psychiatric Association, the American Academy of Child Psychiatry, the National Institute of Mental Health and others to combine in one grand effort and together with politically active ex-patients to educate the public, generate public debate, and forge public consensus which will result in effective political action. Mental health advocacy groups have tended to focus on prevention, on treatment of the acute and “treatable” patient and on community mental health. Until now, seldom if ever have the rights of chronic patients, their economic and social conditions, received the high priority which they deserve. The time is right since the problems of deinstitutionalization are becoming a national disgrace and since there are workable solutions.

In the past psychiatrists have not been able to exert a significant influence on legislators and decision makers. Psychiatrists have been naive about the political process and have erroneously assumed that their professional knowledge alone would assure for them due consideration by legislators. In recent years, professional organizations have become more sophisticated and have learned how to present their experience and scientific findings to the people who have the power to translate this information into mental health policies. In this endeavor professionals have to compete with many anti-psychiatry voices. To gain political strength psy-

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Economic realities

Economic factors are probably the most important determinants of the types and quality of care that will be provided for the chronic mental patients. Issues include competing priorities; funding squabbles among federal, state and local taxing authorities; struggles within the mental health care system between institutional and community-based programs; and uncertainty as to which programs are most economical in both the short term and the long run.

In his report on Insanity and Idiocy in Massachusetts, by the Commission on Lunacy, 1855, Edward Jarvis suggested the construction of a new state hospital by stating:

In whatever way we look at them, these lunatics are a burden upon the Commonwealth. The curable during their limited period of disease, and the incurable during the remainder of their lives, not only cease to produce, but they must eat the bread that they do not earn, and consume the substance they do not create, receiving their sustenance from the treasury of the Commonwealth or of some of its towns, or from the income or capital of some of its members.

Though Jarvis deplored the direct costs to the state for providing care for pauper lunatics, he nevertheless stressed the humanitarian necessity:

The cost of restoring a lunatic to health and enjoyment, and power of self-sustenance, and of contributing to the support of his family, and also of bearing his part of the burden of the State, is limited, and easily paid in money; the gain is unmea-
sured. But the cost of lifelong lunacy, distressing and oppressive to the friends who have the patient in charge, is immeasurable, and not to be paid in money.\(^9\)

The costs in 1855 were minute compared to the present. In the United States the direct costs of care (including health programs, prepayments through insurance, etc.) for the mentally ill in 1971 totaled 10.6 billion dollars.\(^{11}\) The indirect costs of mental illness (including absenteeism, partial disability, time lost to individuals and their families, excess deaths due to mental disability, etc.) were estimated to be at least another 14.2 billion dollars. In addition, about 500 million dollars were spent for administrative costs needed to maintain social welfare and service programs for these people. Thus, in 1971, the total cost of mental illness in the U.S. was conservatively calculated to be 25.3 billion dollars.

The direct costs of mental illness in 1971 represented 13.2 percent of all health expenditures in the United States in that year. Although it is difficult to make direct comparisons because of differences in the methodology used to calculate the expenditures and losses involved, in 1963 the cost of mental illness was estimated to be 7 billion dollars, in 1968 it was almost 21 billion dollars, and in 1971 it was 25.3 billion dollars. This dramatic increase in less than a decade indicates the gravity of the problem of caring for the mentally ill—in the hospital or in the community—a problem whose solutions are influenced fundamentally by attitudes toward mental illness and by the economics of mental illness.

The deinstitutionalization movement has been largely sparked by the hope of many state legislators that closing state hospitals would save money, which could then be used for other pressing state needs. But this is a false hope if the closed institutions are to be replaced with adequate community programs. Economy as the prime reason for deinstitutionalization is a mirage that is disappearing and as it vanishes legislators feel betrayed and become angry. Not only are community programs more expensive than they had been led to expect, but also they must cope with the readmission trends now occurring in states that emptied their hospitals without prior preparation of adequate community care programs.

At a time of rapidly rising costs, particularly for personal services, federal, state, and local governments understandably look for opportunities to reduce expenditures. In most states, deinstitutionalization makes it possible to shift much of the cost of care for the chronically ill away from state appropriations to federal and local budgets, since many patients in the community live on welfare and use Medicaid and community mental health centers. When a municipality or a county pays only a small part of the costs of maintaining patients in the community—but none of the costs of keeping them in the hospital—it is unlikely to become responsive to community care.

Since Medicare, Medicaid, Social Security, developmental disabilities, welfare, mental health, and health policies and regulations are not coordinated, the chronic mental patient has no consistent legislative program operating on his behalf. Discharged chronic patients are often inappropriately pushed onto Medicaid or Medicare rolls so as to use federal dollars when state or local funds are inadequate. Counties overuse state hospitals to avoid paying for local community programs and state governments energetically phase down state hospitals and overwhelm inadequately funded local community mental health programs.

In January 1977, the Federal Government's General Accounting Office published a report entitled, *Returning the Mentally Disabled to the Community: Government Needs to Do More*.\(^{12}\) It must have surprised many readers to realize that under at least 135 federal programs operated by eleven major departments and agencies of the federal
government—including the Department of Health, Education and Welfare (approximately 89 programs), ACTION, and the Departments of Housing and Urban Development and Labor—“almost every type of service needed by mentally disabled persons in communities can be financed wholly or partly with federal funds.”

These funds are often not used because many officials in the federal, state and local governments are not even aware of their availability and are not familiar with the intent and purpose of deinstitutionalization. Furthermore, unrealistic requirements for receiving Medicare, Medicaid and Supplemental Security Income (SSI) funds may have encouraged unnecessary hospitalizations or the inappropriate placement of released patients in nursing homes, ill-equipped for the special needs of the mentally disabled.13

Medicaid funding is available for intermediate-care facilities and skilled-nursing facilities but not for other less restrictive, smaller, more therapeutic community facilities. Furthermore, Medicaid age and eligibility requirements inhibit the development of appropriate programs for the mentally disabled in nursing homes since persons under 65 cannot receive Medicaid coverage for care in a facility in which more than 50 percent of its residents are psychiatric patients. Even though SSI has enabled many patients to return to and remain in the community, the lack of program standards permits the placement of recipients in substandard facilities, their potential exploitation by facility operators, and a reinforcement of their sick role and their tendency towards permanent dependency.14

In 1972, federal regional councils were established for ten geographic areas to improve coordination of the federal grant system with state and local governments. But neither the Office of Management and Budget, responsible for coordination of federal programs, nor any of the five coun-
cils surveyed for the GAO report, have thus far concerned themselves with the coordination of the complex problems of the long-term mental patient in the community. Since these people not only need psychiatric and medical services but also vocational training opportunities, job opportunities and housing, resources outside the mental health establishment need to be involved in cooperative planning.

State vocational rehabilitation programs often avoid the more seriously disabled persons by a subjective interpretation of policies. Even though the Department of Labor administers programs to help the mentally disabled to prepare for and obtain suitable jobs, no systematic effort has been made to reach them. Many persons served by sheltered workshops are not transferred to competitive employment when they are ready. Furthermore, there is usually little coordination between state mental health agencies and state employment offices. The GAO report suggested that states could be induced to help the mentally disabled to find appropriate employment if the Labor Department’s formula for reimbursement of the service costs were improved.

In October 1975, the office of the Department of Housing and Urban Development (HUD) in Dallas helped provide 41 homes and apartments for 170 mentally disabled persons in Texas and New Mexico, while supporting six clinics and centers in three cities that served more than 600 patients a month. This all too rare experience shows how cooperation between HUD and HEW can develop suitable alternatives to institutional care of mentally disabled people. The lessons learned from a successful project should be replicated in various parts of the country. At this time, however, lack of communication and coordination has resulted in a complex and often self-defeating jumble of legislation, programs and regulations that frustrate many well meaning efforts by individuals, agencies, and governmental units.
A COORDINATED APPROACH

To prevent political or economic pressures from adversely influencing the locus of patient care, state mental health systems must be unified to represent a continuum of available services. As long as there is budgetary competition within state mental health systems between institutional and community-based components, patient-based comprehensive planning and implementation of mental health services will be severely compromised if not impossible. Competing systems tend to entrench bureaucratic and “protection of the institution” components, often at the expense of the community component.

Although states have the primary responsibility for the care of the chronic mentally disabled, the Federal Government pays much of the cost for individuals, both in institutions and in communities. Thus far, deinstitutionalization experience seems to demonstrate that the complex problems involved far exceed the ability and commitment of any single government authority. Coordinated sharing of responsibilities among federal, state and local governments is needed, just as treatment, rehabilitation and habilitation demand the coordination of multiple disciplines. Much of the current confusion is caused by mutually exclusive policies among the separate authorities.

A comprehensive national policy

We need, therefore, a comprehensive national policy on deinstitutionalization which establishes federal, state and local responsibilities. As the GAO recommended, each house of Congress should charge one committee with the responsibility to oversee all federal efforts toward deinstitutionalization.

Future federal legislation should include:

- A long-term federal commitment to mental health services to end the current uncertainty about a federal floor of support.
- Consolidation of mental health funds under the special health revenue-sharing and centers program into a formula grant to state mental health agencies. This grant would provide them with greater flexibility in programming and at the same time require them specifically to determine the responsibilities of all agencies concerned in the community care enterprise. It would encourage the preferential development of community services with special incentives.
- Increase the amount of out-patient mental health coverage available under Medicare by amendment of section 1853(c) of the Social Security Act, and make corresponding changes in the Medicaid provisions.
- Specification of minimum standards for community-based facilities for the care of mentally disabled persons, with provisions for adequate monitoring of compliance with these directives. These specifications should provide local governments with guidelines for licensing laws.*

Comprehensive state planning

State governments are the logical planning authorities for deinstitutionalization and community care. The federal program is too remote from the special problems in local areas and local governments are not fiscally strong enough to bear the responsibility.

* When this report was written, the President's Commission on Mental Health, created by President Carter by Executive Order on February 17, 1977, with Mrs. Rosalynn Carter as honorary chairperson and Dr. Thomas F. Bryan as chairman, had only begun its preliminary exploration of the mental health needs of the Nation. The problems of the chronic mental patient in the community were recognized as among the top priorities of concern. It was too early to assess what influence the Commission would exert on the future shape of the problems.
At least one state, California, has attempted to remove the financial advantage to localities of mental hospital care for the chronically ill. The Lanterman-Petris-Short Act of 1968 requires local participation in the care of the mentally ill wherever they are located. The California experience should be carefully reviewed and modified for use throughout the nation so that the locus of patient care can be determined by psychiatric rather than by financial indications. Legislation to make this approach effective should include provisions for:

- Protection of employees in state institutions from financial and geographic dislocation by adequate retraining and reassignment as their institutions phase down or are closed.
- Replacement of the current pattern of preferential discharge of patients into affluent counties by a plan for more equitable distribution of such patients. Special financial support should be given to counties that are financially unable to bear that burden.
- Financial incentives to counties to reduce their long-term hospitalization rates and increase their community programming.
- Financial penalties to counties which fail to provide for their fairly determined chronic care responsibilities.
- Financial support to responsibly organized, self-help, former patient groups.
- Monitoring of community care facilities to insure compliance with established or new federal and state licensing and credential regulations.
- Financial support to families of chronic patients to enable them to assume a greater responsibility for care.
- Funding of local community mental health centers contingent on their assumption of greater responsibility in the care of formerly hospitalized patients.
- Financial and legal support to responsible citizen groups which sponsor volunteer and advocacy efforts on behalf of mental patients.

Local government responsibilities

Local responsibilities for the most part derive from federal or state legislation except for certain large urban counties. Reasonable local government responsibilities include:

- The provision of a share of funding for mental health services according to state/county formulae.
- Administrative oversight of the extent and quality of local programs, including the control of inhibitory community policies, such as zoning and fire ordinances, that inappropriately interfere with integration of former patients into community life.
- The initiation and implementation of programs within the local plan as needed.

Institutional and community care

Defenders of the split-stream funding method correctly perceive the current inadequacies of most community-based programs for the deinstitutionalized mental patient and capitalize on that inadequacy to protect the jobs of institutional workers and the economy of communities in which state hospitals are located. The resistance to deinstitutionalization would diminish, if not disappear, if those jobs were guaranteed, either within the institution or within a community program. If employees in institutions could be convinced that their livelihoods would be protected, their unions might even join in the deinstitutionalization effort.

In the early days of the community mental health movement, the enthusiasm of some psychiatrists and other professionals who viewed community facilities as the ultimate solution for mental health problems led them to promise or to imply that treatment in the community would both solve the problems and save money. By now we know that the authors of Action for Mental Health were correct in pre-
dicting that adequate community care would be expensive. We can either solve the problems or save money; we can't do both.

We consider it intolerable to have the tools and not use them. The only acceptable course is adequate appropriations from public funds to make deinstitutionalization work: (1) by improving the adequacy of community resources; (2) by improving the ways of transferring and maintaining chronic patients in the community; and (3) by realizing that some patients will also need long-term in-patient care. As the GAO report concluded, "When adequately financed and managed community care can be an effective alternative to institutional care."

However, this position must be tempered by the wisdom of the "simple and it seems, inescapable" basic conclusions reached by Bachrach. "The deinstitutionalization movement—a movement intended to counteract the effects of dehumanization in mental health care—can best fulfill its promise if certain conditions are met. Individual mental hospitals are most effectively superseded, in accord with the aims of the deinstitutionalization movement, when: (a) there is a thorough understanding of the functions which they serve in American life; (b) consensus is reached as to which of these functions should be continued or discontinued, or which new functions should be added; (c) effective alternatives are established in community settings for the accepted functions; and (d) sufficient time is allowed for the systematic and orderly implementation of new programs and transfer of functions."

REFERENCES


6. See citation 3.


10. Ibid.


17. See citation 12.

RECOMMENDATIONS

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, and the various methods of achieving rehabilitation should be integrated in all forms of services [italics ours], among them: clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services and expatriate groups.

ACTION FOR MENTAL HEALTH—1961, pp 270–1

This statement on rehabilitation of mentally ill persons by the Joint Commission on Mental Illness and Health is as relevant in 1978 as it was in 1961. The need for improved community care has become even more urgent because the number of patients residing in the community has increased as a consequence of deinstitutionalization policies. Instead of giving a high priority to aftercare and rehabilitation, most community services to the chronically mentally ill have been limited in scope, inadequately financed, uncoordinated in organization, and ineffectual in accomplishment. The tragic neglect of people chronically disabled by mental illness cannot be blamed on ignorance of appropriate methods of treatment and rehabilitation. We have failed as a nation and
as a profession to use methods whose validity has been demonstrated.

To improve the mental health of the country, first priority should be given to the community care and rehabilitation of long-term patients. A greater commitment must be made to continuity and integration of services than ever before. Training, retraining, and redistribution of manpower must be emphasized to improve the responsiveness of professionals and paraprofessionals to the special needs of these patients.

All efforts should be implemented by a community-based system with a wide range of services and facilities structured to provide true continuity of care and to insure adequate treatment and programs for each patient and in each locality. If the system is to be effective, the Federal Government must accept continuing, not transient responsibility for a substantial part of the support of these programs and for the assurance of their quality.

The development of such a system of rehabilitative services requires a renewed national commitment, and the will to reduce the ravages and consequences of mental illness to the extent humanly possible. Many of the principles embodied in our specific recommendations have been expressed before. The need for their implementation has become progressively more urgent. We can no longer afford to delay action.

**SPECIFIC RECOMMENDATIONS**

**Coordination**

We strongly advocate that the Congress establish a nationwide community-based system of treatment and rehabilitation ser-

vices for chronic mental patients of all ages. This system should include community mental health centers, but should not be limited to them.

- Federal legislation is needed to solve problems caused by territoriality of federal agencies and to insure that the resources of the Rehabilitation Services Administration, the Social Rehabilitation Services, the Social Security Administration, the National Institute of Mental Health, the Housing and Urban Development, and other services will be used in a coordinated and effective way.

- Public and private mental hospitals should be integrated into the system. The state hospital should not be perceived as a substitute for inadequate community care but as a resource for patients whose needs are best served by the hospital regardless of the alternatives available in the community or elsewhere.

- A continuum of housing and residential facilities which varies to meet the individual needs of chronic patients in the community should be promoted by adequate licensing, monitoring and fiscal inducements to guarantee standards of care and safety.

- Greater flexibility in catchment areas than is now possible under current community mental health center legislation is essential to permit optimal adaptation of special service programs to the needs of our communities.

- **Coordination** of health services with other relevant human services should be built into the system of mental health care which, in keeping with current scientific insights, should integrate humanistic and interpersonal with biological methods.

- To insure **continuity of care** the case management team concept should be vigorously supported as the basic model for the care of mentally ill children, adults, and the aged.
Financing

We recommend that funding of treatment and rehabilitation services be provided from a combination of federal and other governmental and non-governmental resources on an ongoing basis. Appropriate community care of the chronic mentally ill should be supported not only by health care delivery agencies but by funding related to other human services such as housing, welfare, and education. Barriers discriminating against the mentally ill should be abolished in all public programs.

- The government’s related awareness of the significance of the community care problem is shown by recent changes in community mental health center regulations requiring aftercare services. But these requirements will not lead to adequate aftercare unless supported by categorical funding over a long time span. Categorical federal funding for aftercare and rehabilitation is essential.

- Although shared funding must be accompanied by shared responsibility, the administration of system components should be centralized within a single coordinating authority in order to avoid the fragmentation characteristic of most current community care efforts.

- Rehabilitation programs should be integrated with financial support of ex-patients in such a way that unnecessary dependency is minimized. Principles of rehabilitation medicine should be closely scrutinized and those aspects adopted which deal with planning for rehabilitation at the time of entry rather than at the time of discharge.

- The private sector should be encouraged and enabled to participate in the community care of chronic mental patients by the availability of long-term funding. Adequate compensation through existing or future programs and health plans should be provided for direct services as well as for indirect services, especially consultations to persons, agencies and facilities involved in the support, care or re-

habilitation of chronic patients. The integration of private and public resources will contribute to a more effective and more encompassing system of care. The availability of private psychiatric services through Medicaid in California is just one example of the contribution the private sector can make to the service delivery system.

Education

We consider it essential that training programs for all mental health workers, professionals and paraprofessionals should emphasize experience in the management of chronically ill mental patients and concern for the continuity of their care.

- Psychiatry as a profession must recognize the need to change the attitudes of its members, through continuing education and other measures, away from unwarranted and fatalistic pessimism and towards realistic optimism in the care of the chronic mentally ill.

- Appropriate training should be available to paraprofessionals who provide care and services to ex-patients, especially the operators and the staff of residential facilities.

Research

Although we have not put into practice much of what is already known and would be useful in the care of the chronic mentally ill, there are many relevant areas in biochemistry, psychopharmacology, and sociology that need further exploration. Support for ongoing research should therefore be included in the funding for aftercare and rehabilitation.

- One or more central data banks for the accumulation and dispersion of relevant information are essential in order to make current knowledge accessible to those responsible for planning and implementing plans for the care of the chronic mentally ill.
Professional responsibility

The mental health professions must assume responsibility and provide the initiative for a coordinated effort towards the development of an effective system of care through legislation. Through our professional organizations, through our collaboration with lay organizations and through our academic institutions, we must insist that the provision of humane care for the chronically ill mental patient will be given the high priority which this perennial problem demands.

Particular attention must be paid to insure that chronic patients will be treated in a way that does not demean them and strip them of their dignity. All licensing agencies for residential facilities, all funding sources and all those involved with program evaluation and patients' rights should have this as their highest priority. Priscilla Allen's "Bill of . . . Rights for Citizens Using Outpatient Mental Health Services" states clearly the needs of chronic patients and what the response to these needs should be.

ACKNOWLEDGMENTS TO CONTRIBUTORS

The program of the Group for the Advancement of Psychiatry, a nonprofit, tax exempt organization, is made possible largely through the voluntary contributions and efforts of its members. For their financial assistance during the past fiscal year in helping it to fulfill its aims, GAP is grateful to the following:

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