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Hospitalization of the Mentally Ill Revisited, The

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The Hospitalization Of The Mentally Ill Revisited

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The care of the mentally ill today has returned to the conditions of 200 years ago, when proper hospitalization was unavailable and the inflicted were either improperly cared for by their families or left to wander the streets. "Give me liberty or give me death" said Patrick Henry in 1775 at a time when he had his wife, a mother of six, confined in a basement room. She was disturbed and disturbing, and he had no other recourse. His biographer wrote:

> An insane asylum had just been established at Williamsburg, but it was hardly a place where Henry would have confined his wife. It does seem that she was kept in the basement with a Negro woman attendant--probably the kindest fate for the unhappy woman, considering the horrors in store for the mentally ill in the eighteenth century, whose families were unable to care for them.[1]

The family physician wrote, "[w]hilst his towering and master-spirit was arousing a nation to arms, his soul was bowed down and bleeding under the heaviest sorrows and personal distresses. His beloved companion had lost her reason, and could only be restrained from self-destruction by a strait-dress."[2]

The first revolution in the treatment and care of the mentally ill began in the late 18th and early 19th century when insanity came to be regarded as a disease rather than as divine retribution or demonic possession. At this time, a convergence of popular indignation, growing medical interest, and several actual cases seemed to prove that, with humane treatment, insanity could be cured. In this context laymen and physicians developed a system

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1. R.D. MEADE, PATRICK HENRY: PATRIOT IN THE MAKING 281 (1970).
2. *Id.*

that they called moral treatment.[3] Most prominently, in 1791, Philippe Pinel, in France, introduced humanitarian principles in the care and treatment of the mentally ill that emphasized the role of environment in affecting personality and mental functioning.[4] No longer would "the devil be beaten out of a person." In America, this philosophy of moral treatment was championed by Dr. Benjamin Rush, the renowned political leader of the Revolutionary War period, and the father of American psychiatry.[5] Later, during the 1800s, the cause of moral treatment for the mentally ill was taken up by Dorothea Dix, who carried on a campaign to build state institutions after it had become generally apparent that private philanthropy could not cope unaided with so large a burden.[6]

The philosophy of humane treatment espoused by these pioneers prevailed in the United States in the early part of the 19th century. By the middle of that century, in part reflecting the positive results of humane treatment of the mentally disordered, and in part reflecting the expansionist philosophy of the burgeoning industrial era, there was considerable social pressure to take care of the mentally ill on a larger scale.[7] As a result, palatial manors to house the mentally ill were built by state governments at considerable expense. Most often, these facilities were located in rustic and attractive (though remote) parts of the states. Constructed at a cost unparalleled in the world, these facilities were designed with the premise that madness might be soothed in a setting of archi-

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3. *See generally* J.S. BOCKHOVEN, MORAL TREATMENT IN AMERICAN PSYCHIATRY (1963); N. DAIN, CONCEPTS OF INSANITY IN THE UNITED STATES, 1789-1865 (1964); A. DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES (1949); D.J. ROTHMAN, THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC (1971); J.S. Bockhoven, *Moral Treatment in American Psychiatry*, 124 J. NERVOUS & MENTAL DISEASE 167 (1956); E.T. Carlson & N. Dain, *The Psychotherapy That Was Moral Treatment*, 117 AM. J. PSYCHIATRY 519 (1960).

4. RUTH B. CAPLAN, PSYCHIATRY AND THE COMMUNITY IN NINETEENTH-CENTURY AMERICA ch. 1 (1969).

5. *Id.*

6. *Id.* at ch. 6.

7. GERALD N. GROB, MENTAL INSTITUTIONS IN AMERICA/SOCIAL POLICY TO 1875 (1973) [Hereinafter GROB]; *see also* Gerald N. Grob, *Mental Health Policy in America: Myths and Realities*, 11 HEALTH AFF. 7 (1992).

tectural beauty. This progressive thinking as well as the building efforts it engendered became a model for the whole world.[8]

Charles Dickens, in 1842, noted approvingly that American mental hospitals were supported by the state; a fact which made the government in his view a merciful and benevolent protector of people in distress.[9] As the number of seriously mentally ill persons on the streets and in the jails grew, the various state governments came to accept full responsibility for their care and built larger public mental hospitals. In fact, the constitutions of many states mandated state-sponsored care of the mentally ill.[10] The American scheme of state-sponsored moral treatment was in sharp contrast to the conditions in England, where public charity was minimal, and the government offered the mentally ill, as Dickens said, "very little shelter or relief beyond that which is to be found in the workhouse and the jail."[11]

This era of moral treatment in America, however, was soon to end. As the population increased with the influx of immigrants, the public mental hospitals were turned into welfare institutions, providing a living place for the new immigrants.[12] At the same time, the farms and dairies in the state hospitals which provided meaningful work and activity for the mentally ill residents were generally abandoned.[13] Beginning in the late nineteenth century, business interests seeking to sell supplies to these new welfare institutions, effectively pressured to have the farms and dairies closed. As a result, once meaningful work experiences in the hospital were replaced with a state of idleness, which feed disorder

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8. Grob, *Mental Health Policy in America*, *supra* note 7, at 7.

9. CHARLES DICKENS, AMERICAN NOTES AND PICTURES FROM ITALY 28 (1842) (London 1957).

10. For example, Michigan's Constitution, as revised, provides: "Institutions, programs and services for the care, treatment, education or rehabilitation of those inhabitants who are physically, mentally or otherwise seriously handicapped shall always be fostered and supported." MICH. CONST. art. VIII, § 8. The provision does not set out the mode of care or treatment. The words "programs and services" were added in the 1963 Constitution as "broader concepts not necessarily confined to institutional treatment." *Id.* (Convention comment).

11. DICKENS, *supra* note 9, at 28.

12. GROB, note 7, at 8.

13. CAPLAN, *supra* note 4, at ch. 1.

and distress.[14] The hospital degenerated into the "snake pit," a place of disorder and distress. Its motto became, "Abandon hope, all ye who enter here."[15]

It was during this period that Mrs. E.P.W. Packard began her crusade for the enactment of laws on the hospitalization of the mentally ill as well as laws for the protection of patient rights.[16] Her crusade had its genesis in her own hospitalization. Her husband, the Reverend Theophilus Packard, stating that he could not "manage" her at home, had her committed. To accomplish this, he utilized a state statute which provided that married women could be involuntarily committed on the request of the husband without the evidentiary standard applicable in cases involving others.[17] According to the historian Albert Deutsch, Mrs. Packard claimed to be the Mother of Christ and the Third Person of the Blessed Trinity.[18] Upon her discharge, by writ of habeas corpus, she went on a crusade for the adoption of mental health codes that became the foundation of modern codes. She claimed that sane persons were illegally incarcerated and maltreated. Her attacks, along with exposés by other former patients, resulted in the passage of legislation that would more effectively safeguard the rights of patients and circumscribe the powers of hospital officials.[19]

The second revolution in psychiatry was ushered in by Sigmund Freud at the turn of the century. Like Pinel, Freud engendered hope and enthusiasm in the treatment of the mentally ill.[20] On the basis of a new understanding of human behavior, and the promises of psychiatry, laws were enacted on sexual psychopathology, alcoholism and drug addiction that would divert individuals out of the

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14. *Id.*
15. GROB, *supra* note 7, at 10.
16. *See* BARBARA SAPINSKY, THE PRIVATE WAR OF MRS. PACKARD 180 (1991).
17. S. BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW 9 (1985).
18. DEUTSCH, *supra* note 3, at 424-25.
19. SAPINSKY, *supra* note 16, at 205.
20. *See generally* K.A. MENNINGER, A PSYCHIATRIST'S WORLD (1959); E. Glover, *A Psychoanalytic Approach to the Classification of Mental Disorders*, 78 J. MENTAL SCI. 819 (1932).

criminal law process and into the hospital system. These behaviors came to be regarded as mental illness rather than as crime.[21]

The third revolution in psychiatry occurred in the 1950s, with the development of psychotropic medication.[22] These chemical agents resulted in a decrease in the use of physical restraints, electroshock, hydrotherapy, insulin coma and other physical means of treatment. Medications such as Prolixin, Haldol, and Navane were used to control the voices and delusional thinking of schizophrenia, and lithium was used to control the mania of manic-depressive psychosis. For the first time, there was a decline in the number of persons admitted to mental hospitals.

With this decline, a new philosophy began to emerge, which had as a goal the abandonment of state mental hospitals altogether. Proponents of this philosophy argued that hospitalization itself produces "institutional dependency," which offers not mental health, but mental death, and robs the individual of all incentive. Sociologist Erving Goffman, who had worked for a time as an occupational therapist in a large mental hospital, crystallized this thinking. He wrote that the syndrome known as "chronic schizophrenia," a severe psychosis, is merely an adaptation to the social system of the hospital. In his 1961 book *Asylums*, Goffman presented a scathing critique, not only of the conditions prevailing in mental hospitals, but also of the basic philosophical premises on which such institutions were founded.[23] Thereafter, the word "asylum" became a derogatory term.

In fiction, Ken Kesey in his novel *One Flew Over the Cuckoo's Nest* described the hospital staff as a tyrannical, sadistic group which forced patients into total submission.[24] In still another dramatic view, Dr. Thomas Szasz in his book *The Manufacture of Madness* drew a parallel between the persecution of witches in the thirteenth through the seventeenth centuries and what he termed our

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21. *See* RALPH SLOVENKO, PSYCHIATRY AND LAW chs. 9, 10, 12 (1973); K.M. Bowman & B. Engle, *Sexual Psychopath Laws, in* SEXUAL BEHAVIOR AND THE LAW 757 (Ralph Slovenko ed., 1965).

22. *See* E. FULLER TORREY, NOWHERE TO GO (1988).

23. *See generally* ERVING GOFFMAN, ASYLUMS (1961).

24. KEN KESEY, ONE FLEW OVER THE CUCKOO'S NEST (1962).

persecution in the twentieth century of people labelled mentally ill.[25] In his view, modern psychiatry has led us not to more enlightenment, but only to different victims for persecution.[26]

During the tumultuous 1960s and 1970s, Bruce Ennis, an attorney for the American Civil Liberties Union, lead the Mental Health Bar in litigation to close all mental hospitals.[27] These efforts were unlike those of Mrs. Packard who, a century earlier, sought hospital safeguards and regulations instead of outright closings.[28] In 1972, Ennis and three other young attorneys (Charles Halpern, Paul Friedman, and Margaret Ewing) formed the Mental Health Law Project, which rapidly became--and has remained--the ideological and logistical center of the mental patient liberation bar. They were abolitionists, not reformers, who challenged every assumption of the mental health system.[29]

Ennis's book, *Prisoners of Psychiatry*, a polemic against mental hospitalization, was also published in 1972. In a preface, Szasz praised Ennis for recognizing "that individuals incriminated as mentally ill do not need guarantees of 'treatment' but protection against their enemies--the legislators, judges, and psychiatrists who persecute them in the name of mental health." In this book, Ennis portrayed psychiatry as a means to control or dispose of people who annoy others. As Ennis wrote: "How would we tame our rebellious youth, or rid ourselves of doddering parents, or clear the streets of the offensive poor, without it?" For Ennis, hospitals were places "where sick people get sicker and sane people go mad." In 1974, in an interview published in *Madness Network News*, Ennis stated: "My personal goal is either to abolish involuntary commitment or to set up so many procedural roadblocks and hurdles that it will be difficult, if not impossible, for the state to commit people against their will."[30]

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25. THOMAS SZASZ, THE MANUFACTURE OF MADNESS 111 (1970).
26. THOMAS SZASZ, PSYCHIATRIC SLAVERY (1977).
27. *See generally* R.J. ISAAC & V.C. ARMAT, MADNESS IN THE STREETS ch. 5 (1990).
28. *See supra* note 16 and accompanying text (discussing the endeavors of Mrs. Packard).
29. ISAAC & ARMAT, *supra* note 27, at ch. 5.
30. L. R. Frank, *An Interview with Bruce Ennis, in* MADNESS NETWORK NEWS READER 162 (1974).

Ironically, in the 1960s and 1970s, with some notorious exceptions, mental hospitals were at their best since the era of moral treatment of the early 1800s.[31] Staffing and facilities were greatly improved. In the 1960s, when the allegations of abuse at mental health facilities began to mount, Senator Sam Ervin (later of Watergate fame) held hearings and uncovered no cases of "railroading."[32] The American Bar Association also commissioned field investigations of mental hospitals in six states, and it concluded that railroading was a myth.[33] In general, a patient in a mental hospital who wanted to leave simply had to put one foot in front of the other and walk out. Professor Gerald N. Grob, the prize-winning historian of mental hospitals, has written that the hospitals provided an asylum nowhere else available.[34]

Nevertheless, with liberty said to be at stake, the Mental Health Law Project urged that the due process requirements of criminal justice procedures be applied to the civil commitment process. Another device utilized to restrict the use of hospital commitments was the concept of the least restrictive alternative (LRA), also known as the least restrictive environment. Under this doctrine, state intervention resulting from commitment is to take place in the least restrictive manner. The basis for the doctrine is the constitutional requirement that the state may restrict the exercise of fundamental liberties only to the extent necessary to effectuate the state's interest.[35] Under this scheme, the state hospital was posited

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31. *See generally* GROB, *supra* note 7, at 10. To add to the irony, Bruce Ennis later became legal counsel for the American Psychological Association, and Joel Klein, who was allied with Ennis in the Mental Health Law Project, became counsel for the American Psychiatric Association. Thus, in a turnaround, these outspoken attorneys found themselves responding to their own allegations. One might say that Ennis and Klein created their own jobs.

32. *Constitutional Rights of the Mentally Ill, Hearings Before the Subcomm. on Constitutional Rights of the Comm. on the Judiciary*, 87th Cong., 1st Sess. (1961). Allegedly unjustified hospitalization came to be called "railroading" following the case of Mrs. Packard who was put on a train when sent to the hospital.

33. R. ROCK ET AL., HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 77 (1968).

34. GROB, *supra* note 7, at 10 (1973); Gerald N. Grob, *Rediscovering Asylums: The Unhistorical History of the Mental Hospital*, 7 HASTINGS CENTER REP. 4, 33 (1977).

35. The doctrine developed originally in cases involving the First Amendment. *See* Shelton v. Tucker, 364 U.S. 479, 488 (1960).

as the most restrictive environment, with community-based services and outpatient care seen as less restrictive.

Thinking in terms of liberty, proponents of LRA did not use the phrase "most beneficial alternative." Under the LRA concept, any feasible alternative must be implemented in lieu of involuntary hospitalization. The first enunciation of LRA in the law on hospitalization was in 1966 in the case of *Lake v. Cameron.*[36] This case involved one Mrs. Lake, a sixty-year-old "bag lady." Mrs. Lake carried her worldly possessions around with her in a shopping bag, appearing disoriented, wandering about in the downtown crime-ridden district of the nation's capital.[37] In assessing her habeas corpus petition, the District of Columbia Circuit Court of Appeals ruled that any course of treatment should not exceed the minimum necessary to ensure the patient's protection.[38]

In a case that came before the United States Supreme Court, *Addington v. Texas,*[39] the Mental Health Law Project sought to invoke the "proof beyond a reasonable doubt" standard of criminal justice into the civil commitment process.[40] The case involved a man whose mother filed a petition to have him involuntarily committed to a state mental hospital.[41] The Court held that to require proof beyond a reasonable doubt of the criteria for civil commitment--"mental illness" and "dangerousness" or "gravely disabled"--would be well-nigh impossible, and thereby would do away with involuntary commitment.[42] Chief Justice Warren Burger recognized this. Writing the opinion of the Court, he said that the criminal law "beyond a reasonable doubt" standard was inappropriate because, "given the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an

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36. 364 F.2d 657 (D.C. Cir. 1966).

37. *Id.* at 658-59.

38. *Id.* at 660. The court remanded the case to the lower court for consideration under the least restrictive means analysis. *Id.* at 661.

39. 441 U.S. 418 (1979).

40. *Id.* at 419-20.

41. *Id.* at 420.

42. *Id.* at 428-31.

individual is both mentally ill and likely to be dangerous."[43] Nevertheless, the Chief Justice called for a "clear and convincing evidence" standard in commitment hearings, as opposed to the "preponderance of the evidence" standard of the ordinary civil case and less than "proof beyond a reasonable doubt" of criminal cases.[44]

The emergence of the community mental health center (CMHC) laid the groundwork for the fourth revolution in the care of the mentally ill. The CMHCs were supposedly designed to maintain patients in the community, thereby sparing them the allegedly dreadful consequences of institutionalization.[45] Based on a community services approach to mental health care, the Landerman-Petris-Short (LPS) Act,[46] was regarded as the "outstanding accomplishment of the California Legislature in its 1967 session."[47] It was designed to keep hospital population down by limiting commitment, thus saving liberty while saving money.[48] The LPS Act was hailed as a model to which all other states could look, and it was even called "the Magna Charta of the mentally ill."[49] The Act was designed to "protect the civil liberties of persons alleged to be mentally ill" and to accelerate the trend toward "community" treatment of the mentally ill as an alternative to hospitalization in remote state institutions.[50] Presumably, the mentally disturbed would be willing to come to the center with small problems before they became big ones, thus shifting the state's role from custodial to preventive.

President Kennedy was impressed with the Report of the Joint Commission on Mental Illness and Health, *Action for Mental Health.* He endorsed it, and made funds available for its

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43. *Id.* at 429.
44. *Id.* at 433.
45. L.L. BACHRACH, DEINSTITUTIONALIZATION: AN ANALYTICAL REVIEW AND SOCIOLOGICAL PERSPECTIVE 52 (1976).
46. CAL. WELF. & INST. CODE § 5000 (West Supp. 1992); *see* F.W. MILLER ET AL., THE MENTAL HEALTH PROCESS ch. 5 (1976).
47. ISAAC & ARMAT, *supra* note 27, at ch. 6.
48. *Id.*
49. *Id.*
50. *Id.*

implementation.[51] The Report echoed Goffman's critique of institutionalization. The CMHC program had the support of both the political right and left. The right wanted to close the mental hospitals to save money, and the left thought it was freeing prisoners of snake-pit psychiatric bureaucracy.[52] At the time, there was little or no support among policy makers for mental hospitals. Many legislators and judges were persuaded by both the legal and psychiatric professions that mental hospitalization was both outdated and expensive.[53] The community mental health program was sold to legislators on the basis of saving money--an argument very appealing to a legislator's heart.[54] For example, the legislators after whom the 1967 California commitment law was named (Lanterman-Petris-Short) were members of the Ways and Means Committee--a finance committee--and were, therefore, probably most concerned about the state getting its moneys' worth.

The change in the treatment of mental patients precipitated the change in funding sources for mental health care facilities from the states to the federal government. In 1963, when CMHCs were first funded and deinstitutionalization, the total amount of public funds spent on the mentally ill was approximately a billion dollars per year. An estimated ninety-six percent of these funds came from the states. Following passage of the CMHC Act, the configuration of fiscal responsibility changed. The first change was a liberalization of rules making mentally ill individuals living in the community eligible for federal benefits under the Aid to the Disabled program. This program was subsequently incorporated into the federal Supplemental Security Income (SSI) program[55] for individuals who did not qualify for Social Security benefits, and into the Social Security Disability Insurance (SSDI) program for those who did qualify.[56] In addition, a federal Food Stamps program, which

51. TORREY, *supra* note 22, at 90. *See generally* H.R. LAMB, THE HOMELESS MENTALLY ILL (1984).
52. TORREY, *supra* note 22, at 90.
53. *Id.* at 97.
54. *Id.* at 128.
55. Social Security Act of 1935, Pub. L. No. 92-603, § 301, 86 Stat. 1465 (1935).
56. *Id.*

could also be used by mentally ill individuals in the community, was enacted in 1966.[57]

At the same time, other federal programs were enacted that paid part of the costs for mentally ill patients in nursing homes and in the psychiatric units of general hospitals, but provided relatively little for such patients in state mental hospitals. These programs were Medicaid,[58] enacted in 1965, and Medicare, enacted in 1966.[59] Medicaid and SSI require states to provide some funds to match the federal subsidy, whereas Medicare and SSDI do not have this requirement. Even with the matching funds, however, states, in turning to nursing homes, save at least fifty percent of the costs of inpatient and outpatient psychiatric care by the use of the federal programs above. As a result of the shifting fund base, the 552,150 beds occupied nationwide in 1955 in state mental hospitals was reduced by over eighty-five percent.[60]

Economics was the primary motivation in the deinstitutionalization of the mentally ill.[61] As a result, the tax dollars not spent on hospitalization did not follow the patient into the community.[62] During these changes, no one seemed to ask about the "community" in mid-twentieth century America. In places that might be truly considered a community, the reaction to the CMHC program has been expressed in an acronym, NIMBY (not in my backyard).[63] The mental hospital may not be a rose garden, but compared to urban America, it smells and looks a whole lot sweeter. Since the 1950s, the saying "Abandon hope, all ye who enter here" applies more appropriately to the inner cities than to the mental hospitals.

Ironically, when mental hospitals were known as asylums, the environmental pattern of the communities from which the

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57. Food Stamp Act of 1964, Pub. L. No. 88-525, 78 Stat. 703 (1964).

58. Medicare Act of 1965, Pub. L. No. 89-97, § 1, 79 Stat. 286 (1965).

59. *Id.*

60. TORREY, *supra* note 22, at 3.

61. M. J. Mills & B. D. Cummings, *Deinstitutionalization Reconsidered*, 5 INT'L J. L. & PSYCHIATRY 271 (1982).

62. D. A. Treffert, *The Dollar Flows to the Patient, Not the Dollars*, *in* UNIFIED HEALTH SYSTEMS: UTOPIA UNREALIZED: NEW DIRECTIONS FOR MENTAL HEALTH SERVICES 33 (1983).

63. S. Sandler, *The West Side Has Lost Patience*, N.Y. TIMES, Nov. 7, 1992, at 15.

individuals came was close-knit, small-scaled and personalized. At one time, service and amenity facilities were in pedestrian proximity. But today, when the mental hospital is no longer regarded as an asylum, the environmental pattern of the so-called community is loose-knit, large-scaled, and depersonalized. Service and amenity facilities are only in automobile proximity. For survival, the denizen in today's so-called community must exercise his constitutional right to bear arms and to negotiate the hazards of an expressway in order to get around.[64]

The grounds of any state hospital offer more freedom of movement than the streets of the inner cities of America.[65] Regarding the community placement of Mrs. Lake, the "bag lady," Judge Burger (later Chief Justice of the Supreme Court) dissented, saying, "[t]his city [the nation's capital] is hardly a safe place for able-bodied men, to say nothing of an infirm, senile, and disoriented woman to wander about with no protection except an identity tag advising police where to take her."[66] One would be hard pressed to argue that conditions in the inner cities are any safer today.

Without the structure and support afforded in the hospital, medication is used more extensively in the outpatient setting. Medication was condemned when used in the hospital, but it is now used even more to alleviate symptoms and make possible resocialization, remotivation, rehabilitation, and reemployment.[67] The CMHC was supposed to bring about an era without snake pits, without exploitation of patients, and without deprivation of liberty. Unfortunately, it has not turned out that way. Today, the CMHC system has resulted in high costs to families and society as well as to the individual. As Los Angeles Superior Court Judge Eric Younger put it:

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64. R. SLOVENKO, *Mobilopathy*, 12 J. PSYCHIATRY & L. 293 (1984).

65. R. SLOVENKO, *Crime Revisited*, 18 J. PSYCHIATRY & L. 485 (1990).

66. Lake v. Cameron, 364 F.2d 657, 664 (D.C Cir. 1966).

67. *See* Felce v. Fiedler, 974 F.2d 1484, 1494 (7th Cir. 1992); NORMAN Q. BRILL, AMERICA'S PSYCHIC MALIGNANCY 111 (1993).

> Crazy people are now everywhere. Modern notions of civil liberties and fiscal considerations have combined to produce a population of very disturbed people in every city in America. The notion of local treatment alternatives for mentally incapacitated citizens is a cruel hoax. It is clear that the vast majority of dangerously impaired people are out there on the streets.[68]

The shift from large institutions to nursing home care or other facilities is not deinstitutionalization, but re-institutionalization--a new custodialism replete with its own failures and shortcomings. In 1984, John Talbott, as President-elect of the American Psychiatric Association, pointed out that more than fifty percent of nursing homes were populated by persons with primary or secondary diagnoses of mental disorder; thousands of disturbed persons wander the urban landscape without housing; and legions inhabit welfare hotels, board and care homes and adult residences.[69]

Many of the chronic mentally ill, who previously were housed in state hospitals and worked on hospital farms or dairies or in laundries, kitchens, and housekeeping services, functioned better, had greater feelings of self-esteem, and contributed more to their own existence than they do now in the so-called community system.[70] Now these patients are on their own, and they are given low priority in the CHMCS where the focus is on the less impaired patient.[71] A hospital bed often is not available when needed and with increasing frequency these chronic, rejected, and displaced patients end up in jail. Years of progress in state hospital care have been reversed by penal custody, which has often become the treatment of choice.[72]

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68. BRILL, *supra* note 67, at 113.

69. J. A. Talbott, *Psychiatry's Agenda for the 80s*, JAMA, May 4, 1984, at 2250.

70. BRILL, *supra* note 67, at 113.

71. *Id.*

72. A study in Massachusetts reports that 27 percent of those discharged from state psychiatric hospitals became homeless within six months; a similar study in Ohio found the figure to be 36 percent. And an increasing number of mentally ill people are in jails and prisons. A recent survey found that, on any given day, there are approximately 30,700 persons with schizophrenic or manic-depressive illness among the 426,000 inmates in the nation's local jails. Many of these mentally ill inmates have no charges against them but are merely being held in jail awaiting transportation to or

Those who originally advocated deinstitutionalization and community treatment programs supported the claim that not only would their programs be more effective, but that CMHCs would cost less.[73] Now, these advocates bemoan the lack of adequate funds and attribute their failures to it.[74] Their vision of a system of clinics, halfway houses, day-care centers, nursing homes, skilled nursing facilities, general hospital beds and residential facilities would require, by far, a budget that would exceed previous costs associated with traditional hospitals.

The asylum concept has been abandoned. The CMHC system is basically a non-supportive and non-medical system, without commitment to research or interest in developmental and familial factors. Instead of treating the seriously ill, the CMHCs have turned into counseling centers for marital problems, existential crises, adolescent turmoil, and general unhappiness. The physical disorders of many patients go either unrecognized or untreated, which is evidenced by the fact that many CMHCs do not even have an examining room.[75] Separating psyche from soma, they dichotomize the treatment of sick people. Dr. Donald G. Langsley was prompted to ask, "Does the community mental health center treat patients?"[76]

Often to the dismay and fear of families, neighbors, and others in the community, thousands of psychotic individuals have been discharged from hospitals.[77] In the oft-quoted words of Dr. Donald A. Treffert, these patients are left to "die with their rights

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the availability of a bed in a state psychiatric hospital. *See* J.F. Torrey, *The Mental-Health Mess*, NAT'L REV., Dec. 28, 1992, at 22. More than seven percent of the people held in the nation's jails are seriously mentally ill, according to a report released by Public Citizen Health Research Group and the National Alliance for the Mentally Ill. *See Many Seriously Mentally Ill Confined in Jails, Not Getting Help*, PSYCHIATRIC NEWS, Oct. 2, 1992, at 7; *see also* R. Blumenthal, *Emotional Ill Pose Growing Problem to Police*, N.Y. TIMES, Nov. 16, 1989, at 1. Copies of *Criminalizing the Seriously Mentally Ill* are available from PUBLIC CITIZEN, Dept. CRP, 2000 P St., N.W., Suite 605, Washington, D.C. 20036.

73. TORREY, *supra* note 22, at 114.

74. *Id.* at 202.

75. BRILL, *supra* note 67, at 114.

76. Donald G. Langsley, *The Community Mental Health Centre: Does it Treat Patients?*, 31 HOSP. & COMMUNITY PSYCHIATRY 815 (1980).

77. ISAAC & ARMAT, *supra* note 27, at ch. 5.

on."[78] There are crippling limitations of mental illness that do not yield to current treatment methods. Apathy, withdrawal, submissiveness and passivity may not be the result of hospitalization as many have claimed in promoting de-institutionalization, but symptoms of the illness itself.[79] Patients with these conditions are pushed into communities less able to care for them than the hospitals.

A program presumably developed for the protection of individual rights and for providing better care and treatment has in many instances turned out to be doing the exact opposite. Chronically and seriously disturbed patients, formerly hospitalized, now are in facilities like nursing homes, board and care homes, and adult residences, where the level of care and treatment is seriously compromised.[80] The result is a situation where not only are the societal rights ignored, but where patients' rights have also diminished.[81]

In some instances, families, when assisted by the CMHC, have been helpful in the rehabilitation of the patient. But such success is more apt to be with the less severely ill and less disturbed individuals whose behavior is less bizarre and where contact with reality is less impaired. These patients do not impose as much of

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78. Donald A. Treffert, *Dying with Your Rights On*, 2 PRISM/SOCIO-ECON. MAG. A.M.A. 49 (1974).

79. BRILL, *supra* note 67, at 115.

80. *Id.*

81. Gerald N. Grob, *Mental Health Policy in America: Myths and Realities*, 11 HEALTH AFFAIRS 7 (1992). In this article, Grob writes:

> In mid-nineteenth-century America the asylum was widely regarded as the symbol of an enlightened and progressive nation that no longer ignored or mistreated its insane citizens. The justification for asylums appeared self-evident: They benefitted the community, the family, and the individual by offering effective medical treatment for acute cases and humane custodial care for chronic cases. In providing for the mentally ill, the state met its ethical and moral responsibilities and, at the same time, contributed to the general welfare by limiting, if not eliminating, the spread of disease and dependency. After World War II, by way of contrast, the mental hospital began to be perceived as the vestigial remnant of a bygone age....Before World War II the focus of America's efforts to treat its mentally ill citizens was on those individuals who suffered from the most severe and chronic problems. Since 1960 public policy has emphasized creation of a centralized system of services. In the process, the target populations became diffuse, and services were no longer focused on the most severely ill people.

Id.

a burden on families as those who are much sicker, more regressed, more bizarre, more out of contact, and more out of control--but who, despite the severity of their symptoms, were discharged from hospitals because they were not considered homicidal or suicidal and presumably were able to take care of themselves.

In cases where institutionalization is needed, admission to a private hospital under Medicare has often been denied by a hospital utilization review committee, contrary to medical opinion.[82] Other mentally ill patients who seek voluntary treatment in state hospitals may be turned away because there are no beds available.[83]

We have come full circle back to the days of Patrick Henry. Once again, for lack of care and treatment, families lock up a disturbed or disturbing member, or they wander the streets. The state hospitals have been often maligned, but they fill a vital need. Even with the best community support system, there are individuals who need an asylum. The critics of the hospital system in the 1960s and 1970s were acclaimed, but by the end of the 1970s, the failures of deinstitutionalization had become all too apparent.

The families of chronic patients are protesting. In the 1950s and 1960s they were loosely organized, but today they have formed political action associations with chapters in virtually every state. They want legal reform to make involuntary commitment easier and they want increased public funding and services for the mentally ill.[84]

The overall population of state psychiatric hospitals has been reduced from 559,000 in 1955 to about 100,000 today. Many of the seriously mentally ill are now walking the streets or sitting in jails.

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82. S. Rachlin, *The Psychiatrist--Administrator in the Economic Crossfire, in* REVIEW OF CLINICAL PSYCHIATRY AND THE LAW, ch. 13, at 209 (R. I. Simon ed.); WILLIAM A. CHITTENDEN, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 453 (1991); C. Pierce, *HMO Sued After Patient Kills Children*, CLINICAL PSYCHIATRY NEWS, August 1992, at 1.

83. BRILL, *supra* note 67, at 115.

84. *See generally* J. Q. LAFOND & M. L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES (1992).

The reason is the virtual demise of public psychiatric hospitals as the caring and treating agency for individuals with debilitating mental illness. It mocks our pretense of being a civilized nation.[85]

85. P. Chodoff, *Jails and Mental Illness*, PSYCHIATRIC NEWS, Dec. 4, 1992, at 21.