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DEINSTITUTIONALIZATION OF INDIANA STATE MENTAL HOSPITALS; A STAFF REPORT.

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By

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Preface

This staff report was developed to better understand the need for community residential services to "chronic" patients. The topic of deinstitutionalization is quite complex and this report reviews the social science literature on this topic and develops planning recommendations. Statistical data is also presented. Further research is needed into the various aspects of the deinstitutionalization process for the Indiana State Mental Hospitals.

DEINSTITUTIONALIZATION OF INDIANA

STATE MENTAL HOSPITALS; A STAFF REPORT

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In striving to improve the level of psychological and social functioning in our society and the quality of services available to the afflicted, we must remember that the many problems we face, of which mental health is only one, must be attacked not only through medical and educational indeavors but also within the content of an improving society, which strives toward greater social justice and a true sense of compassion for the weak and sick.

David Mechanic, Mental Health and Social Policy

It may be, however, that this society cannot mount a cooperative effort to change its social institutions. Issues of power and control may so preoccupy its decision-making members that improving the social position of its marginal members will be given a low priority. If such is the case, no research, however valid, can change those aspects of the society that are inhumane and unjust.

George W. Fairweather and Others, Community Life for the Mentally Ill

Preface

Publications such as Mental Disorders In Urban Areas by Faris and Dunham, Social Class and Mental Illness by Hollingshead and Redlich plus others provide insight into the causation of mental illness, especially in urban areas. While the estimated number of mentally ill people would vary according to the definition of mental illness and the survey process, many people do seek psychiatric services. In the recent past, these people were served in state hospitals usually located away from their community. (Some people did receive treatment by private professionals.)

Today, community psychiatric resources are expanding and there has been a dramatic decline in state hospital population. The return of the ex-patient to the urban area and the development of community services has changed how the mentally ill are served in urban areas. Thus, while the above and similar books help one to understand the relationship between urbanization and mental illness, the public administration task of providing needed services under rapidly changing conditions remains.

Introduction

A recent social problem has been the reduction in the population of state mental hospitals. The return of ex-patients to urban communities and placement in nursing homes have been discussed in the popular press and professional literature.[1] There has been a reduction in the population of the Indiana State Mental Hospitals and a forecast that this trend will continue.[2] There is a need for social planning to insure that ex-patients who are returned to Indiana's urban areas receive their needed care, training, and therapy in a dignified and humanitarian manner.

Objective of Study

The objective of this study is to review the social science and related literature and develop social planning recommendations for the deinstitutionalization of the Indiana State Mental Hospitals.

Brown[3] has developed an operational definition of deinstitutionalization with three essential components as the following:

1. The prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment;

2. The release to the community of all institutional patients who have been given adequate preparation for such a change;

3. The establishment and maintenance of community support systems for noninstitutionalized persons receiving mental health services in the community.

The following is a short description of the Indiana State Mental Hospitals.

There are six state hospitals that serve primarily the mentally

ill for all of Indiana. Each of these state hospitals has a geographical district composed of counties. The hospital district is compatible with the boundaries of catchment areas for community mental health centers. Each of the planned thirty-two mental health centers is assigned to a single state hospital. The alcoholic and drug abuser is served in the mental illness state hospitals.

The six district Indiana State Mental Hospitals include Dr. Norman Beatty Memorial Hospital at Westville (LaPorte County), Logansport State Hospital at Logansport (Cass County), Central State Hospital at Indianapolis (Marion County), Richmond State Hospital at Richmond (Wayne County), Madison State Hospital at Madison (Jefferson County), and Evansville State Hospital at Evansville (Vanderburg County). Beatty State Hospital has a specialized maximum security unit that serves the whole state.

There are two specialized state hospitals serving primarily the mentally ill (Evansville Psychiatric Children's Center at Evansville, plus LaRue D. Carter Memorial Hospital at Indianapolis).

Fort Wayne State Hospital and Training Center at Fort Wayne (Allen County), New Castle State Hospital at New Castle (Henry County), and Muscatatuck State Hospital and Training Center at Butlerville (Jennings County) are the three zonal state hospitals for all of Indiana. These zones are compatible with the three Health Systems Areas. Northern Indiana State Hospital and Training Center for Developmental Disabilities at South Bend serves as a specialized state hospital. Each of these four state hospitals serves the mentally retarded and other developmentally disabled. Developmental disabilities includes cerebral palsy, epilepsy, and similar handicapping conditions.

Review of the Literature

Functions of State Mental Hospitals

Clausen[4] provides the following functions of a mental hospital.

> The mental hospital may be characterized as a social establishment designed for the custody or care of persons who have exhibited a degree of mental disturbance which makes it difficult, dangerous, or inconvenient to incorporate them into normal family and community living arrangements. The public mental hospital is a legal repository for such persons, on the one hand, and a medical institution for treatment and care of patients, on the other.

Szasz[5] suggests that state hospitals have an economic or income redistribution function.

> As a result, major cutbacks in the expenditures of the mental health bureaucracy threaten the same kind of economic dislocation as do cutbacks in the expenditures of the defense establishment are, perhaps, equally "unthinkable."

Thus, mental hospitals have social control, custodial care, treatment, and income redistribution functions in our society.

Growth and Decline of State Hospital Population

The development of the state mental hospital in the United States in the late 19th century was a reform movement to improve the status of the mentally ill who were inadequately served in community jails, attics, and other living arrangements. Bart[6] suggests that the moral treatment approach of the early state hospitals was abandoned for the "warehousing" in asylums usually located in rural areas with the influx of immigrants to state hospitals. The decline of Social Darwinism led to changes in treatment of mental patients with the current emphasis on treatment in the community.

The number of patients in state mental hospitals rose to 558,922 in 1955 and dropped to 193,436 by 1975.[7] A variety of factors including the development of community based services, changes in admission

policies of state hospitals, plus others are discussed as the reasons for this decline.[8]

Hisle[9] shows that the population in Indiana State Mental Hospitals rose to 15,583 in 1955 and declined to 6,637 by 1976.

Mental Illness as Deviant Behavior

A brief discussion of mental illness as a type of deviance should be introduced at this point to show how complex it is to determine the need for state hospital and community services. Angrist[10] suggests that there are at least four positions or approaches on the nature of mental illness.

> The first approach asserts that mental illness is a type of deviant behavior. A second position takes the basic promise that mental disorders are pathology or disease in the psychology or psychiatric sense and not pertinent to conformity-deviance theory, which is concerned with interactions in a social system. A third approach looks on some types of mental disorders as deviant behavior while other behavioral constellations are defined as illness or medical phenomena. Still a fourth standpoint calls for specifications of the definers of behavior according to their social status and degree of professional training.

The labeling theory in sociological literature stresses that deviant behavior is in part a product of social definitions imposed on a person by society. The psychiatrist and sociologist interpret behavior differently.[11]

> For example, whereas a psychiatrist would be prone to say (or imply) that a certain individual acts the way he does "because he is psychotic" sociologists tend to reverse the syntax - the individual is psychotic because he acts the way he does. The difference is not merely a choice of words; it reflects a basic contrast in perspective.

The psychiatrict Szasz[12] and sociologist Scheff [13] support the labeling theory of mental illness while Gove[14], a sociologist, feels that people hospitalized do have serious psychiatric disorders and

this theory is incorrect.

Mental Health Planning

The different approaches to define mental illness as described above plus the difficulty and expense to determine a "true count" by using available survey methods makes accurate incidence and prevalence data difficult to obtain. However, Solomen and Palch[15] have an approach that seems to be a practical remedy to this problem.

> For example, the case is made that treated patients comprise only a fraction of such patients; however, in a given locality, the factors that influence the value of that fraction probably do not change greatly over a short time, and data concerning treated patients do bear some relation to "true incidence" and "true prevalence." These data thus probably represent not only the best estimate of incidence and prevalence available but also useful estimates of these parameters . . . Indeed, the nature of the field is such no matter how much investigative effort is devoted to it, the conclusions arrived at will probably always have an irreducible amount of uncertainty. The wise approach would seem to be refine techniques as much as possible (as feasibly and as flexibly as can be done) and plan programs on the basis of the data, humbly realizing not only that the plans will be imperfect, but that where the imperfections lie cannot always be known.

Thus, while it is complex to determine the needed state hospital and community services, this planning task can be done within limits.

The accumulated knowledge found the social sciences, psychiatry, and public administration should be used to help forecast, plan, implement, and evaluate needed services to the mentally ill, the mentally retarded, and developmentally disabled, plus the alcoholic and drug abuser. The value of knowledge is in the betterment of mankind. According to Waitzkin, social planners believe . . ."that accurate data about social problems will contribute to social change, ordered according to a rational plan. This belief is based on the assumptions that a comprehensive plan, once developed, will be carried out actuality."[16]

Experienced social planners know that the pure rational model to

planning needs to be tempered with the "art" of planning in using political processes. When there are alternatives plus values involved, the political process should make the final decision based upon the best possible data and knowledge of the consequences of each choice. Planning should be with the people affected by the implementation of such plans.

Mental health planning fits the following description by Moore.[17]

> Uncertainty and lack of precise predictability arise from the complexity of dynamic patterns - that is, from a rather large "error" factor owing to the number and interplay of uncontrolled variables.

The mental hospital, as a social organization, will next be discussed.

The Mental Hospital as a Social Organization

Parsons[18] provides a definition of a social organization.

> It seems appropriate to define an organization as a social system which is organized for the attainment of a particular type of a goal; the attainment of that goal is at the same time the performance of a type of function on behalf of a more inclusive system, the society.

Johnson[19] also has a definition of organizations.

> Organizations are (1) goal-oriented, people with a purpose; (2) psychosocial systems, people working with groups; (3) technical systems, people using knowledge and techniques; and (4) an integration of structured activities, people coordinating their efforts.

What happens to a social organization whose function is no longer needed by society? When the Salk vaccine was discovered, the National Foundation for Infantile Paralysis changed its goals to fight birth defects as reported in Sills.[20] When threatened by the loss of purpose, a goal displacement process may occur in which "official" goals are replaced by survival techniques.

However, one could view a state hospital as one sub-system of a

larger social organization, the Indiana Department of Mental Health. A change in function of the state hospital will alter other sub-systems, the community agencies. The changing functions of sub-systems within a social organization creates problems of goal integration. A total system point of view provides a basis for integrating goals of sub-systems into a systematic whole.[21]

While one can observe the deinstitutionalization process from a systems viewpoint, an individual person is the patient or client involved. This individual human being must often navigate through complex social systems. Scott[22] speaks to this point.

> Clients who are expected to be prime beneficiaries of the activities of service organizations are often in a relatively weak position and therefore have difficulty in protecting their interests. The inability of clients to evaluate the services proferred them by the technically skilled organization members is one source of their weakness, and their problems are compounded in those cases where their participation is involuntary, as it is, for example, in public schools and, to a lesser degree, in public welfare agencies.

The following is a discussion of the review of the literature.

Discussion

The deinstitutionalization of state hospitals needs to consider the functions that such hospitals play in our society. The social control function has been lessened by recent court decisions and the increased usage of voluntary admissions. Judges can admit patients to community mental health centers as well as state hospitals.

The custodial function is beginning to be developed in the community by the development of halfway houses and alternate residential care services for the mentally retarded and developmentally disabled. The Department is assuming an increasing public housing function as

custodial care shifts to the community. This new function should be recognized. There needs to be increased coordination with land use planners over zoning and other requirements of developing these community residential services. The possible increased use of nursing home facilities require the joint planning with Health System Agencies. The placement of patients into community settings plus not admitting people who used to be sent to a state hospital for social reasons means a close working relationship must be developed with social agencies as well as private practice professionals. Standards need to be monitored to insure that proper care is given.

The treatment function will be increasing assumed by the community mental health centers. However, these facilities will need to increase their capability to treat many of those patients who in past times were sent to state hospitals.

The income redistribution function may be more difficult to move to the community setting. Many of the state hospitals are in rural settings and the local economy depends upon the state hospital as an industry. The deinstitutionalization process spreads the money to more communities but those areas where a state hospital is reduced may suffer. This is a complex problem that should be recognized.

As discussed above with the social control function, the change in state laws and court decisions has influenced the development of community services. While such laws could be changed and court cases decided that would slow or reverse the deinstitutional process, it appears that the trend is in the other direction.

"Label Jars Not People" was a headline in a recent publication of an agency serving the mentally retarded. While academic people can argue about the merits of labeling theory, there does seem to be a trend toward increasing tolerance and understanding of people who might appear to be "different." However, values in our society have changed in the past and as we go into the future, Social Darwinism thinking may become more pronounced.

Careful mental health planning is needed to insure that this reform movement back to the community will be handled in the best interest of the patient. The Department's "business" is service and this service can best be provided by a mix of state hospital and community settings.

The state hospital is a social organization. The deinstitutionalization process will change this social organization and dynamic change is needed for this social entity to survive. This change must be well planned with staged implementation to insure that patients (as well as staff) do not get forgotten.

Social Planning Recommendations

1. There should be increased capability within the Department to provide consultation to communities who want to develop halfway houses, small group homes, and other community residential services for the "public housing" or custodial function. This expertise is not now available. The knowledge of zoning requirements, housing values, mortgage payments, and other topics needs to be available to communities. There is also the need for coordination of health, safety, and fire inspections between other state plus local authorities.

2. The Division of Professional Services within the Department (this Division contains professionals that provide consultation to

the state hospitals and community agencies) should make inspections to a sample of the alternate living arrangements to observe the level of care, training and treatment and how such services are provided. These placements are monitored but a special survey should be performed to insure quality of care. These inspections should be coordinated with other Divisions (especially the Division on Mental Illness, Mental Retardation, and Other Developmental Disabilities, plus Addictions), other state agencies (especially the State Board of Health when nursing homes are reviewed), local direct service agencies plus advocacy groups.

3. A special study on the economic impact of deinstitutionalization should be contracted. A study on the potential fiscal impact of closing a state hospital has been conducted. However, this recommended study should show how State and Federal mental health funds are being spent through the state as well as at the locations of the twelve state hospitals.

4. Utilization review committees should be organized between state hospitals and community agencies that would screen admissions and assist in discharge planning.

5. There should be the continued development of community mental health centers, mental retardation centers, halfway houses, small group homes, and other services according to the current State Mental Health Plan. The continued development of community alternatives should help avoid inappropriate admissions plus assist in placement of ex-patients back to the community.

6. Additional attention needs to be given to the delivery of mental health and other support services to the elderly. Mental health centers and clinics should make extra efforts to seek out the elderly who need psychiatric services but who are unable or perhaps unwilling to come to

to the direct service providers. Coordination is needed with social planning for the aged, which would include such programs as homemaker service, meals on wheels, recreation, day care, plus others. Since many elderly are in nursing homes, mental health services should be provided to these patients also.

7. The following are some topics within the deinstitutionalization process that should be further researched.

a. A study should be conducted on the effectiveness, efficiency, and productivity of the state hospital and community agencies. The study by Smith and King, Mental Hospitals, materials from the National Commission on Productivity and Work Quality, plus other sources could be used. Attention should be given to patient discharge rate and staff ratio.

b. A cohort study of admissions from a representative month should be conducted. Such a study would examine the length of stay by hospital by demographic and diagnostic characteristics.

c. A study should be conducted on the type of patient who is now in the hospital by diagnosis. Are we treating "sicker" patients than in prior years?

Summary

There has been a dramatic reduction in state hospital population here in Indiana and the United States. This deinstitutionalization process of returning ex-patients to urban communities plus screening of inappropriate admissions to state hospitals needs to be carefully planned to insure that proper care and treatment is provided. The literature on deinstitutionalization was reviewed and discussed plus social planning recommendations were developed. Topics for further research were presented.

Footnotes

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[5]Thomas S. Szasz, Idiology and Insanity, Doubleday and Company, New York, 1969, page 46.

[6]Pauline B. Bart, "The Myth of the Value-Free Psychotherapy," in Wendell Bell and James A. Mau, eds., The Sociology of the Future, Russell Sage Foundation, New York, 1971, pp. 114-115.

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[11]Jack P. Gibbs in Robert A. Scott and Jack D. Douglas, editors, Theoretical Perspectives and Deviance, Basic Books, New York, 1972, page 50.

[12]Szasz, op.cit.

[13]Thomas A. Scheff, Being Mentally Ill: A Sociological Theory, Aldine Publishing Company, Chicago, 1966.

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[15]Philip Solomen and Vernon D. Palch, Handbook of Psychiatry.

[16]Howard Waitzkin, "Truth's Search for Power: The Dilemmas of the Social Sciences," Social Problems, 15 (Spring, 1968), pp. 418-419.

[17]Wilbert E. Moore, Social Change, second edition, Prentice-Hall, Inc., 1974, page 3.

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[19]Richard A. Johnson, Fremont E. Kast, and James E. Rosenzweig, The Theory and Management of Systems, Third Edition, McGraw-Hill Book Company, 1973, page 24.

[20]David L. Sills, The Volunteers, The Free Press, Glencoe, Ill., 1957.

[21]Johnson, op.cit., page 31.

[22]W. Richard Scott, in Robert Faris, ed., Handbook of Modern Sociology.

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APPENDIX

The purpose of the appendix is to describe the statistical change in state hospital populations between 1967 and 1976 and discuss possible future changes in the number and type of patients that may be served.

Graph Number One shows the number of patients present in all Indiana State Mental Hospitals from June 30, 1876, to June 30, 1976, a hundred year period. Patient present is defined as those patients in the hospital plus those on visit or authorized leaves of seven days or less. Patients enrolled includes the patients present and all patients on leaves more than seven days. This graph shows a steady growth of people in the state hospitals with a peak in the fifties and a sharp decline in the late sixties and middle seventies.

What type of people were served in the six district state hospitals during the period of rapid decline? Chart Number One shows the patients enrolled by age by selected hospitals on June 30, 1967, as compared to June 30, 1976. There was a decrease in each age category in each of the selected hospitals except for the increase in the 25-34 age classification for Logansport, under 15 and 15-24 for Madison, and 15-24 for Richmond.

Chart Number Two shows the percentage of patients enrolled by age for these selected State Hospitals. There has been a general decrease in the older age classifications and an increase in young adults. However, it appears that on June 30, 1976, the hospitals have a similar mix of patients by age as they did on June 30, 1967.

Chart Number Three shows the admissions by age for the six selected state hospitals between FY67 and FY76. Central and Richmond had less admissions in FY67 than FY76. The other hospitals had more admissions in

FY67 than FY76. There was an increase in admission in the 15-24 and 25-34 age classifications for Central and Richmond. There was an increase in admissions in the 15-24 grouping at Madison.

Chart Number Four shows the percentage of admissions and reflects the general decrease in admissions of all age categories except for the young adult population.

"HISLE REPORT"

Number of Patients Present, Enrolled, Admitted, and Discharged from State Mental Hospitals from June 30, 1876 to June 30, 1976.

By

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June, 1977

Deinstitutionalization and the Law

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ABSTRACT. Deinstitutionalization, while worthy of implementation in the case of many institutionalized retarded persons, may be fraught with personal and legal problems for others. These problems do not draw into question the overall value of deinstitutionalization or goals and strategies relating to it. They do require a careful examination of the benefit of deinstitutionalization for each affected person and of the process by which a decision is reached to carry out a particular community placement. Legal arguments may be advanced to require such an examination and to support an individual's claim to an institutional placement rather than a community one.

A new and major goal in the field of mental retardation is deinstitutionalization. This term refers to the return of persons residing in centers for the mentally retarded to community or home environments.

A compelling impetus in the deinstitutionalization movement is the assertion of legal rights on behalf of institutionalized retarded individuals. While the movement and this impetus are commendable and worthy of society's best efforts, there are unresolved implications in the deinstitutionalization process. Some of these are raised, not as objections to deinstitutionalization, which the authors support where in the best interests of the retarded person; rather, they are discussed as considerations directly affecting the individual, not the value of deinstitutionalization or general goals and strategies related to it.

It is anomolous to speak of the law and deinstitutionalization without at the same time speaking about the law and institutionalization, for what is at stake either is a decision as to the person's appropriate life style, a decision as to what is the "best" placement of that person, whether in an institution or within the community in some smaller institution. Accordingly, many of the legal issues that will be discussed have relevance to both deinstitutionalization and institutionalization.

Two words of caution are in order: first, there are innumerable legal issues in deinstitutionalization, not all of which are discussed here; and, second, some of the legal issues that are discussed are more in the realm of projecting what the state of the law should be or might become than they are settled legal principles. The discussion of these issues is deliberately selective, speculative, and argumentative.

Due Process

As a general rule, a "voluntary" admission of a mentally retarded person can be lawfully made by the parents or guardian of the mentally retarded person, subject only to the approval or withholding of approval by the institution's administrators. At the same time, the decision to deinstitutionalize the person frequently is also lawfully made by only the administrators of the deinstitutionalizing facility, the person's parents or guardian, and the administrators of the community facility to which the person is being transferred. At no time in these decisions does the retarded person have a right, or even an opportunity, to make a decision for himself, to affect a decision being made for him by others, or to even participate in the decision-making process—when the decision vitally affects his lifestyle, his "best" placement, where he will be, and who will take care of him in what situations and surroundings.

Recently in an institution for the mentally retarded, a 30-year-old resident, who is severely physically handicapped, commented, "I am not trying to brag but I am not mentally retarded. Do you think I should be in this institution?" Upon investigation, it was discovered that he has an IQ of 77 and, arguably, he should not be in an institution for the retarded. Although the placement decision was made on his behalf and seemingly in his best interests by his parents, he was excluded from the decision-making as to his most suitable living arrangement. This particular individual has written letters to legislators and state agency officials and informed them that he has been inappropriately institutionalized. He does not understand the legal details related to due process; however, he understands the basic premise that he should have a right to participate in the decision concerning his lifestyle.

Considerations of extending due process to retarded residents in regard to discharge can also work in the other direction. When a young adult residing in a nearby residential institution was approached as to the possibility of leaving the institution and living in a community group home, the retarded individual was outraged and insulted. He was very happy with his institutional lifestyle and wanted to remain in the institution. The decision was made by professionals that a community placement would be more normalizing; however, he did not want to live in a community environment. Does this individual have the right to choose the institution as his most appropriate placement?

The law has denied a right of opportunity to participate because it traditionally thought of the retarded person as being unable to participate in those decisions, and because it has assumed that the person's parents and the administrators of the institution in which he is placed will act in his best interests. Yet the best interests of the retarded person are not always the same as, and indeed frequently conflict with, the best interests of the parents or the administrators.

If there is a conflict of interests, then it is inappropriate for the law to sanction any process which excludes the mentally retarded person or his independent advocate from the decision-making process. When a person is on trial for a criminal offense and pleads temporary insanity at the time of the offense or the inability to stand trial for the offense because of mental incapacity at the time of the trial, he is not required to do so through his own effort but is entitled to a lawyer to assist him. It may seem a bit far-fetched to argue the criminal analogy with respect to the placement of a retarded person, but the considerations are the same. A decision is made to place a person (in one case, in a prison or in an institution for the mentally ill; in the other case, in a mental retardation facility); the person is not capable—or is not fully capable—of meaningfully participating in and arguing his interests during the decision-making process; and the public's interests are represented (at the criminal trial by the prosecuting officials and in the placement process by the parents and by the administrators of the facilities). The crucial difference is that, in the criminal proceeding the mentally ill person has a right to have somebody appointed by the court or selected by him to argue his interests; whereas in the placement of a mentally retarded perosn, the retarded person has no right to have a person appointed by anyone or selected by him to argue his interests. The decision to place the mentally retarded person in an institution or a community-based facility is analogous to, and the same considerations in those placements are involved in, placement in the parental home, a foster home, a group home, or with friends of the retarded person or his family.

There are some other procedural matters in which the law is inadequate. What process is followed in a decision to institutionalize or deinstitutionalize? Is it a quasi-judicial process in which the various and conflicting interests and claims can be advanced and impartially resolved? Who has a right to be or in fact is involved in that process? Is a judgment made on the basis of all of the facts involving not only the retarded person but also his family, the institutions, and their suitability for him? Are the facts presented to and reviewed by an independent, objective person? Must his decision be made solely on the basis of the facts presented to him? Who presents the facts to him? What are the operative facts? Finally, does an appeal lie from that person's decision? If so, to whom—an impartial review agency? Almost without exception, the answers to these questions are negative.

In all but one instance where the public, through government, takes action with respect to the liberty or property of an individual, the law has insisted upon "due process"—a right to confront the public or its representatives and be heard by an impartial arbiter before the public takes action with respect to the individual. The glaring exception has been the decision to place a person in an institution for the mentally retarded or to deinstitutionalize him. The state of the law now is that, as a general rule, due process is granted only with respect to the placement of a retarded person in special education programs, but not in the far more confining, liberty-depriving placement in institutional or community-based facilities or in parental or surrogate parental homes.

The numerous persons involved in a placement decision—parents, social workers, institutional administrators, psychologists, physicians, teachers, and sometimes judges—have enjoyed substantial immunity in the placement process with the exception of the judges, whose decisions are at least usually appealable to higher courts. Their decisions, both individually and collectively, have frequently been accepted by the persons affected; more often, their decisions have been implemented without the person affected being involved or having a chance to approve the decision, participate in it, or object to it. This immunity, however, may soon become obsolete, for litigation is underway challenging the placement decisions, with parents and legal advocates for retarded persons suing the decision-making professionals on the grounds that due process has not been adhered to in making the decision.

Professional Liability

A second kind of litigation challenging the professionals' immunity from legal procedures and exculpability from the effects of their decisions will be forthcoming—the law suit by the affected person or by his legal representatives (parents, guardians, or next of kin) based on the torts committed by the professionals—malpractice, negligence, or tortious interference with the person. Consider, for example, the case of a trainable mongoloid child who, for each of the 12 years of her life, has been in an institution and knows no life except an institutional one. The decision to place the child in the institution was made by her parents on the advice of a pediatrician who admits to having no training with respect to mental retardation and who made the decision based on his general knowledge of retardation and particularly of mongolism—"these children simply can't learn anything,

they can't be trained, they will die soon, and they ought to be out of the home." A decision such as this undoubtedly is grounds for a lawsuit for professional malpractice. Malpractice litigation now bedevils the physicians. If similar advice had been given by a psychologist instead of a physician, it most likely would not have been actionable by malpractice litigation. But surely the standards of professionalism that the law applies to one profession should be appropriately applied to others, especially where the medical professionals frequently jointly participate with other mental retardation professionals in placement decisions. It is safe to predict that malpractice litigation will soon be brought against the social workers, institutional administrators, psychologists and educators whose professional advice is sought and followed in placement decisions. If they give unprofessional advice, they should be held accountable for their failure to give professional advice measuring up to and consistent with standards of professionalism in their respective professions.

The following passage is quoted from a report of a psychological evaluation conducted by a licensed clincial psychologist: "This young girl with an IQ of 52 will never be able to do so much as write her own name or cross the street by herself. Institutionalization should be carefully considered before the parents become further emotionally involved." This psychologist did not realize the capabilities of a person with a 52 IQ. Luckily, the parents of this child failed to take this advice, and the child is presently achieving at the third level in a public school special education class. Where would the child be now if the advice of the psychologist had been followed? Would there have been grounds for malpractice?

Exactly what constitutes professional malpractice by a psychologist, an administrator or a teacher may be hard to define, but the glaring cases of malpractice are not difficult to identify, and they will initially set the standards for professional competency for money damages. An additional remedy must be granted. It should consist of a review of the decision that was grounds for malpractice and an effort to correct the wrong decision, remedy the improper placement, and secure appropriate placement. If the law will hold the decision makers accountable for their placement decisions, then no longer will it be possible for an administrator who seeks to reduce the population of his institution to single out a retarded resident and require that person to leave the institution without first making a decision, professionally supportable and based on all of the relevant evidence, not necessarily in the best interests of the administrator, the institution, the parents or other affected persons.

The Duty of Preparation

A third emerging legal problem is to define the role an institution plays in preparing parents, a resident, the receiving facility and the community in general for deinstitutionalization. It should not be legally sufficient that a decision to deinstitutionalize is made if the decision is not able to be properly administered in the best interests of the retarded person.

The parents of a 12-year-old mongoloid child who was institutionalized at birth have rarely visited their child in the last 12 years, their teen-age children do not know they have a retarded younger sister, and the family is totally unprepared emotionally and physically to have the 12-year-old retarded child at home. The child has learned the relevant skills essential for home and community living, and the institution is ready to discharge the child. Does it have the right to discharge a child to a family who clearly cannot handle the situation? What are the institution's duties in family preparation? If a child returns to his family and the family later discovers that it cannot effectively cope with home placement, what recourse does the family have?

The duty of preparation also applies to training the retarded person. What happens to the retarded adult who is discharged to the community with no prior training in sex education? If he commits a sex offense without being provided adequate sexuality training by the institution, should not the institution be held legally accountable? As an example of the need to prepare the community, consider the 18-year-old who, having returned to the community, bought several bottles of beer at a local tavern and was arrested for intoxication. The officer testified that he looked funny and slurred his words and was walking awkwardly. The court, upon this evidence alone and without benefit of a breathalyzer or blood test, convicted him. But—the young man always looked funny (he was monogoloid), he always slurred his words (he had a speech impediment), and he always walked awkwardly (he had gross motor difficulty). He was not drunk, simply retarded.

Counseling the parents, making preparations in the community, working with the receiving facility, and training the retarded person himself for community placement, are not yet recognized as legal responsibilities of a deinstitutionalizing facility. Nor will these become legal responsibilities until legislative or administrative regulations are adopted requiring preparation for deinstitutionalization or until the courts hold that the professional at the deinstitutionalizing facility are professionally responsible to carry out those duties and may be held accountable in a malpractice action for their failure to perform them or may be restrained from deinstitutionalizing a person if they have not complied with the duty of preparation.

The Obligation of Equivalency

A related concern deals with the availability or unavailability of services in the community. Again it should not be legally sufficient that a retarded person is discharged to the community if there is not available in the community the same kind and quality of services available to him at the discharging institution.

Many people assume that any community is well suited to provide a continuum of services to the retarded person and that the community is unequivocally the most appropriate placement. What about the community that provides no educational programs to moderately, severely, and profoundly retarded individuals? In some cases of deinstitutionalization, the retarded person has left an educational program or a sheltered workshop in the institution and has been discharged to a community environment in which programs are unavailable. Has his lifestyle improved or has he lost opportunities for development?

Services at institutions and in the community are not what they should or can be but community services should at least be the quantitative and qualitative equivalents of services at the discharging institution. If they are not, the retarded person falsely has been adversely affected by a governmental decision by being denied the same quantitative and qualitative services in the community as he had in the institution, and therefore has been injured and has a right to be recompensed for his injury. Some court decisions in right-to-treatment litigation hold that a person who is institutionalized on account of his retardation has a constitutional right-to-treatment as a person *quid pro quo* of his being institutionalized. It requires only a small extension of this right to hold that a person discharged into the community retains the right although he is no longer institutionalized as long as he can demonstrate a need for treatment. It would be not only unfortunate but also constitutionally doubtful if the state could avoid its duty of treatment by deinstitutionalizing a person.

If this extension of the right-to-treatment can be made, the effect will be to insure that an administrative discharge of an individual can be judicially reviewed. Even if procedural due process standards are complied with, the right-to-treatment argument will allow a retarded person to argue and prove that he still has a need for treatment. If the community into which he is discharged has community- or home-based facilities, then perhaps his need for treatment can be met in that form.

The tough case, however, occurs when the two choices are total maximum institutionalization or complete discharge from treatment and control. In that situation the retarded person, if he can prove he is harmed (deprived of treatment) by the discharge, should be allowed to return to or remain in the institution.

If this sort of lawsuit is allowed, administrators of mental retardation facilities might defend their actions as being consistent with the "least restriction alternative" rationale. This argument was first used by commentators who have recently been writing persuasively that a person whose liberty is infringed upon by the state should have the right to the least restrictive form of commitment; in the case of mental retardation, they argue for the least restrictive form of treatment. The idea has been successfully argued in some mental retardation litigation, and the basic argument is often used by administrators to discharge patients from the facility. The argument is probably legitimate when there are adequate alternative (i.e., community) treatment facilities available to a retarded person. But when there are no alternative facilities, the least-restrictive-form-of-treatment justification for dismissal is clearly invalid, and should be no defense to a right-to-treatment suit brought with the purpose of preventing deinstitutionalization or returning a patient to an institution. The only time it should be a defense is when there are community facilities available and the resident can benefit at least as much, if not more, from the community facilities than from the institution.

If a person is going to be injured or damaged by the community placement, he should be entitled to money damages, but if money damages will not compensate him adequately, he should be entitled to a court order that he not be deinstitutionalized until quantitatively and qualitatively equivalent services are available in his new placement setting.

The Transfer of Rights

It is not clear that the rights possessed by a resident of an institution survive his deinstitutionalization and carry over to the community. In North Carolina, for example, legislation affords residents of mental retardation centers certain rights, but no legislation provides that they shall have the same rights when they are deinstitutionalized to a group home, a foster home, their parents, or some community facility. Do they still have the right to privacy and to ownership or personal belongings? Should they have an individual evaluation and habilitation plan as was required when they resided in the institution? Who in the community is to be held responsible for informing the person of his rights and advocating on his behalf? The same legal recourse arguable available to a person deprived of equivalent services upon his deinstitutionalization should be available if in-institution statutory rights are lost upon deinstitutionalization.

The Duty of State Subsidy

A legitimate public and private concern is the cost of deinstitutionalization. How do the costs for community-based care compare with the costs of institutional care? ("Costs" include not only fiscal costs, which may be originally higher for community care than for institutional care but which over the long term may be lower, but also "costs" saved in terms of human gains.) If they are less, and if the retarded person is being returned to his parental home or even to some nonpublic home such as a foster home or group home operated by an association of retarded citizens, the state is saved the greater costs of institutionalization, but the cost is transferred from the public sector to the private sector. Should not the government—the public sector—provide some recompense or subsidy of the costs of retaining the retarded person in the community at a private facility? What about the case of a deinstitutionalized child who goes back to a community where he is excluded from public school programs or possibly too young for public school? One recourse of his working parents is to place him in a private day care center at approximately $150 to $200 per month. While he was previously living in the institution, the state subsidized the cost of his training program; however, upon discharge to the community, his parents were required to assume the financial burden from the state. One father of a severely retarded boy living at home commented that he is often tempted to teach his son to commit a criminal act. If the boy were a criminal, he could receive rehabilitation at state expense. However, since he is not a criminal and he is retarded, the boy is excluded from many public programs and the family must purchase private care. There is no clear duty now of public recompense (and the duty will come only from legislative action), but the savings to the public sector are obvious if deinstitutionalization is made to a private facility and the state should not so easily escape the costs of its responsibility of care for the retarded person. Recompense could take the form of direct transfers of money, living cost subsidies, social security benefits, and tax credits, among others.

The Duty to Monitor

A major problem is that of monitoring the quality of the care in the community. For purposes of argument, assume that the quality of care in the institutions is monitored and that standards are set and met to adequately safeguard the retarded person while he is in an institution. (To assume this is to ignore the evidence that there is insufficient monitoring or no monitoring at all and that the standards of care are far below what is legally tolerable.) The law has not yet begun to address issues of monitoring the care and setting standards for the care of retarded persons in the community, except insofar as it requires compliance by community facilities with building codes, fire codes, and related standards for the physical facilities in which the retarded will be living. The law is just now beginning to define and provide for the types of community services that make deinstitutionalization possible. The law has yet to address whether the now emerging standards for care and treatment in the institutions will be applied to deinstitutionalized persons, and, if so, whether they will be applied to both governmental and private facilities and professionals. What happens when the management and operation of group homes is detrimental to the welfare of the retarded individuals living in them? Who monitors the quality of service delivery? For example, consider the case of a retarded adult in a nursing home who is afforded no opportunities for self-development or self-expression. This does happen far too often, since few monitoring systems have been developed.

The retarded person might successfully contend that he would be endangered or injured if he were deinstitutionalized to a facility or persons not required to live up to the standards set for his care in the institution. Accordingly, he might be entitled to money damages or an order restraining his deinstitutionalization.

The Right of Voluntary Discharge

Another issue concerns the right of a resident to leave an institution if he has been "voluntarily" admitted or has "voluntarily" admitted himself. If voluntary admissions are in fact not made by the retarded person himself but rather by various persons affected by that decision, and if the retarded person decides that he wants to leave the institution (voluntary discharge and deinstitutionalization), should he have that right? In North Carolina, legislation provides that a person voluntarily admitted to an institution for the mentally retarded may, upon several hours' notice given to the administrators in writing, receive an automatic discharge. While one's innate senses of civil liberties and rights might be warmed by this legislation, one's senses might also recoil at it if the automatic discharge of a "voluntary" admittee results in his return to the community in which he is not prepared to live or a return to a community that is not prepared to accept him.

At one of the regional centers in North Carolina a "voluntarily" admitted adult patient requested his discharge and received it within several hours after his request. He thumbed a ride down to a nearby interstate highway and then, while he was thumbing a ride along the interstate highway—knowing the rules of the road, was struck and killed by a car whose driver was driving lawfully

but who could not avoid hitting the retarded person when he jumped in front of the car, apparently thinking that the car would be able to stop within the available distance. A review of the voluntary discharge legislation seems required if only because administrators of the institutions have failed to prepare their resident for community living. Should an administrator of a discharging institutions be liable to the retarded person, or his estate, if the discharge results in injury that would not have come if the retardate had been properly prepared for discharge?

The Legal Assumption in Favor of Parental Custody

Another issue surrounds the legal presumption in favor of custody of a child by the parents—a presumption that rests on the assumption that the parents are the best persons to care for their child. The parents may have been the persons who initially institutionalized their child; they also may be financially, psychologically and physically not as well equipped to deal with and provide for the retarded child as a group home facility, a foster home, or adoptive parents. Should parents be encouraged to deinstitutionalize their child when it is obvious they do not have the coping skills to make successful adjustments? When a retarded child is returned to a highly unfavorable home environment where supportive services have failed to bring about change, should parental custody be denied?

When the assumptions in favor of parental custody are or might be in error, the legal presumption should not exist, and an independent determination into suitability of the parents should be made.

The Parental Veto

A related issue is the almost absolute right of parents to object to or veto the placement of their retarded child in a community facility other than their own home or in a foster or adoptive home. If the institution wishes to deinstitutionalize a retarded person and if the parents do not want to have the retarded person returned to them, the only alternative for deinstitutioanlization is placement in the community with some persons other than the parents. This placement sometimes will be objected to by the parents for a variety of reasons: the unsuitability of the alternative placement; the implicit rebuttal by the alternative placement of the parents' judgment that institutionalization was best for the child in the first place; the sense of guilt that parents feel when confronted with the possibility that other persons are capable of taking care of a retarded child in the community although the parents themselves were not, as evidenced by their placement of the child; and the parents' sense that they are or will be socially stigmatized if they have a retarded child at home. A pending case at a nearby institution involves an 11-year-old child who has developed the necessary skills for home and community living; however, her parents refused to take her home and have vetoed alternatives such as a foster home or a group home placement. A father commented in a recent parent interview: "This institution is the ultimate place to be, and it gives me such mental comfort to know my daughter is here." Should this child be required to spend the rest of her life in the institution because her parents have refused to have her at home and have denied permission for an alternative placement? Where do the parents' rights end and the child's rights begin?

The legal presumption in favor of parental placement needs to be reconsidered and the parents' ability to object to or veto other deinstitutionalizing placement should be curtailed when deinstitutionalization is in their child's best interests but not in their own.

The Duty of Truth in Placement

There has been very little "truth in placement" in institutionalizing or deinstitutionalizing a person. While federal and state legislation regulates truth in lending and the sale of consumer products, no legislation requires "truth in placement." No legislation requires an institution or a community facility to disclose to the persons making the placement its financial strengths or weaknesses, its staff-to-residents ratio, the programs that will be made available or are not available, the types of diet provided, the fact of compliance or noncompliance with local building, zoning or fire codes or with accreditation standards, the professional qualifications or on-the-job experience of its staff, or other matters relating to the suitability of the facility and its staff for the retarded person. Thus, the parents of a retarded person or his guardians might have to place him in an institution without having the benefit of detailed information concerning the facility itself. If, as has happened, the facility has to close for various reasons, the entire agonizing, expensive and time-consuming process of replacement must be embarked upon

again. A further refinement of "truth in placement" legislation would be legislation obligating a private facility to post a financial responsibility bond, or obligating a public facility to provide financial recourse, for parents or guardians who are put to any expense because of the closing of the facility. When such an important issue as placement is at stake, some form of disclosure should be required so that the placement decision can be founded upon all available facts, and some form of recompense in the form of a financial responsibility bond of assurance should be made if placement cannot be fulfilled.

Refining Guardianship

The entire law of guardianship needs to be explored and refined. Traditionally, a court appointed guardian is available to a person who is incompetent to manage his own affairs; accordingly, a guardian can be appointed for most retarded persons. Traditionally also, the guardian is wholly and entirely responsible for the management of the affairs of his ward; accordingly, the guardian of a retarded person has the absolute authority over the property and even sometimes over the person of his ward. This concept of total guardianship is inconsistent with the emerging models of retardation, which teach that retarded persons are capable of performing some functions and making some decisions for themselves. If a retarded person is capable of managing his property and money, and deciding the amount or type of social freedom he wants, the laws of guardianship should be revised to provide for a limited guardianship in which the guardian has only partial control over certain aspects of the property or person of his ward. If the emerging models of retardation correctly teach that there are degrees of retardation and capabilities among retarded persons, there should thus be degrees of guardianship, tailored to the particular individual and his capability, rather than a single type of guardianship, the complete guardianship, tailored to outdated and invalid assumptions.

Conclusions

Much of the law of mental retardation is just now being developed, and its implications are in the throes of being initially explored in light of our new understanding of retardation and our new sense that retarded persons are entitled not only to human rights but also to legal rights. The warehouse-type institution is not the least restrictive setting for the care, habilitation, training and development of retarded persons. In some institutions, the most shocking infringement of rights has been found. Living conditions are so deplorable that they raise questions of whether the Eighth Amendment, prohibiting cruel and unusual punishment, has been violated. Some types of "treatment" employed in them raise questions of unconstitutional intrusions into the life and liberty of the residents. Rights to education and treatment, although tenuous in the community, are most likely to be denied in institutions. And rights of the retarded person and his family are most likely to be surrendered under a theory of *in loco parentis*, a theory that holds to the belief, so widely contradicted by the evidence, that institutions will act as parents would in the best interest of the retarded residents. It is largely because of the failure of our institutions that we have adopted the belief that deinstitutionalization by less restrictive forms of placement is the constitutionally required placement.

And yet a word of caution is in order: deinstitutionalization, without necessary legal safeguards, will not be a satisfactory answer to the problems of institutionalization, but will merely be an unwitting way for replacing the infringements on legal and personal rights that retarded persons have suffered in institutions by similar infringements to be suffered elsewhere. In short, we must apply the fullest legal protections that the person in the institutions are now belatedly and partially receiving to the persons who are being deinstitutionalized.

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1D. A survey should be made of the employees of the Indiana Department of Mental Health to determine their staff development needs at this point in time (April, 1975). This information would provide baseline data for a staff development program to meet the needs of the mental health delivery system in 1980.

1E. There should be a continuous staff development program organized to meet the changing needs of the state hospitals. The staff development program should include such things as pre-service and inservice training programs, self-study, planned work experiences, visits to other state hospitals and community agencies (including out-of-state trips) horizontal transfers within the state hospital system and the Central Office, exchange employee program within state government, and community agencies, participation in state and national professional organizations, attendance at state, regional, and national conferences, encouragement of applied research and the publication of the findings by an in-house publication or national periodicals, and other such adult learning experiences to enable the employee to be more valuable to the state hospital.

1F. The adult educator at the Central Office level and at the state hospital should recognize the Department of Mental Health as a social organization as well as a unit of state government. There is a very definite informal structure that exists with the formal table of organization. There is a large number of employees with many years of service who know each other. The adult educator will need to be able to work with the informal system, especially if the organization is threatened with lay-offs or closing of a hospital. The Central Office needs to recognize that, while he may have authority, he will need to

earn the power to implement his programs within a state hospital managed often by a medical doctor with considerable independence. Each hospital has its own social system and relationships to community agencies. The reference groups of many of the staff may be more concerned with in-hospital programs rather than hospital-community activities. However, the reference group of newer staff members may be oriented toward community programs without an understanding of the possible contributions of a state hospital. A staff development program should address both situations. As state hospitals become smaller there may occur a administrative change in a state hospital. Some state hospitals have already moved from departmental to an unit system. More personnel will be working with community agencies and some departments, such as nursing, dietary, maintenance, and others will lose employees.

1G. As state hospitals become smaller they will become more multi-purpose and serve mentally ill, mentally retarded and developmentally disabled, plus the drug abuser and alcoholic. A staff development program will need to upgrade the clinical skills to serve patients who have traditionally not been served in a particular state hospital. State hospitals that have formerly served mainly the mentally ill will have additional mentally retarded patients. State hospitals that have specialized in serving them mentally retarded may need to serve the mentally ill patient.

1H. More attention should be given to public education and information by the adult educator. The consumer of the services and the general public should have a better understanding of mental health (as opposed to mental illness) and should know what to expect if they seek professional services for an emotional problem.

Ramification

2. If the patient population continues downward as forecasted, then a General Assembly may decide to close one or more state hospitals before 1980.

Recommendation

2A. The Department should develop general plans to close a state hospital that includes the treatment needs of the patients and the employee rights. This would be a general plan that could be readily adapted to any of the state hospitals. This plan should include special provisions for a state hospital serving the mentally ill as well as a state hospital serving the mentally retarded and developmentally disabled.

2B. The Department should work very closely with unions, employee associations, and professional societies who represent the staff members at state hospitals to insure proper communications.

2C. The reduction of census or the closure of a state hospital may result in some older employees deciding to take an early retirement. The state hospital should provide pre-retirement planning as a part of the staff development program for these people.

Ramification

3. If the patient population continues downward as forecasted the administrative staff at the Central Office and the state hospitals may not have all the management skills to accomplish this task in the best manner possible.

Recommendation

3A. The Department should develop a management training program to upgrade the skills of administrative staff members in the Central

Office and state hospitals. Consideration should be given to contracting with the School of Public and Environmental Affairs at Indiana University for a specialized inservice training program. Resources at other universities should also be considered. Also, the Department should consider having new staff members with backgrounds in operations research, systems analysis and similar fields. Scholarships should be provided to current employees to upgrade their skills to meet this need. Such scholarships would provide a career ladder for current employees.

3B. While the Department of Mental Health may be providing less direct services through state hospitals, more responsibility will be given to our planning, implementing, monitoring, and evaluating enlarged community programs. The management training program should include skills necessary to properly manage an expanded community program. Program standards should be developed for patients placed in nursing homes, halfway houses, small group homes, apartments, and other community living situations. Standards, rules and regulations, plus licensing requirements for community mental health centers, private psychiatric hospitals, day care programs for the mentally retarded and developmentally disabled, alcoholism and drug abuse treatment programs, and community residential services should be further developed and enforced.

3C. There should be developed a contingency plan to provide vocational training to staff members who might be layed off if a hospital closed.

3D. The managerial training program should not only include those people who hold top administrative positions but middle management personnel who often have a fine background in a clinical discipline, but little background in administration.

3E. The following are some of the subjects that could be included in a management training program in addition to basic administrative skills: labor relations, use of data, supervisory training, use of the computer, administrative law, cost-benefit analysis, use of PPBS and other budgetary systems, program planning and evaluation, organization theory, operations research, dealing with regulatory agencies, and other such topics.

3F. Since most state hospitals and state aided community agencies have in-house closed circuit television, this media could be used in the staff development process.

Ramification

4. The reduction in the number of patients in the state hospital system plus the growth of community agencies will change the organization of the state hospitals and the Department as a whole.

Recommendation

4A. The state hospital system should become more "open" rather than relatively "closed" as in past years. More emphasis should be placed upon joint learning experiences between state hospital personnel and people in the Legal system (lawyers, prosecutors, judges, police, correction officials, and others), Medical system (family doctors, private psychiatrists, public health nurses and paraprofessional staff, hospital administrators, hospital trustees, pharmacists, and others), Welfare system (caseworkers, supervisors, directors, welfare board members, welfare rights groups, private social agencies and others), plus the Education system (teachers, guidance counselors, principals, directors of special education, superintendents, school board members, parent-teacher organizations, and others).

4B. There should be the continued interaction between the Department of Mental Health and other state agencies such as the State Board of Health, Department of Public Welfare, Department of Public Instruction, Department of Corrections, State Division of Planning and other units of state government.

4C. There should be more contact between the Department of Mental Health and private funders and third party payers of mental health programs, such as Lilly Endowment, Indianapolis Foundation, WHAS Crusade for Children, Indiana Blue Cross, private insurance companies, and other such organizations.

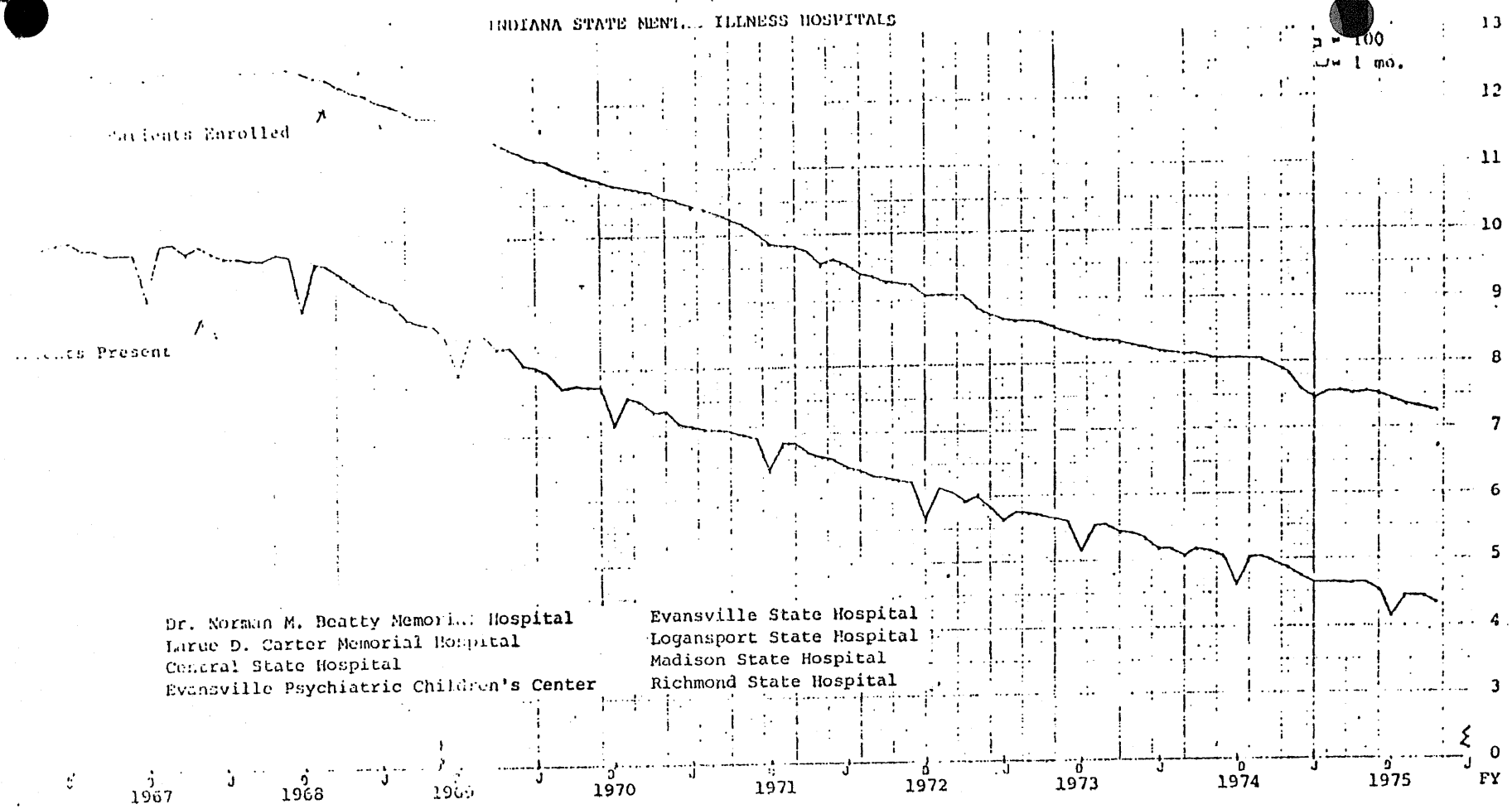
4D. Staff training in Organizational Development should be provided to both state hospital and community agency personnel to assist in the organizational changes that will occur.

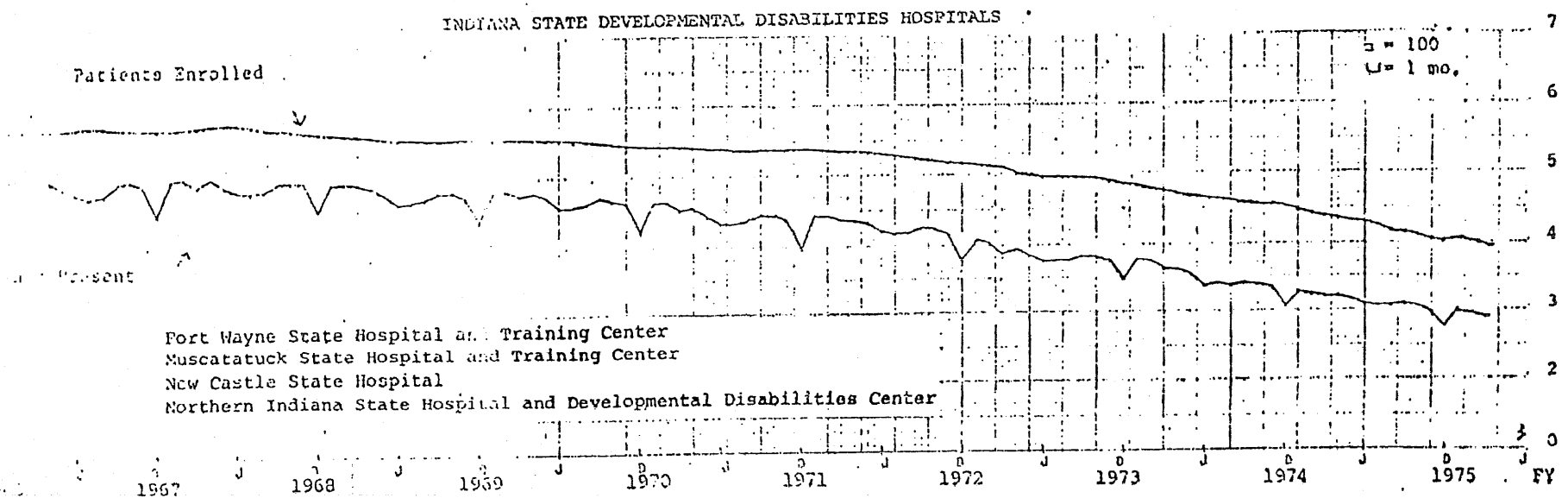
4E. Policy decisions at the highest political level will be needed on the state hospital's organizational role to service long-term chronic patients, many who are aged, who do not need intensive psychiatric treatment and who are not dangerous to themselves or society.

4F. The Department of Mental Health should further develop the "Zonal Planning" between MR/DD agencies and state hospitals serving the MR/DD patients. Also, the "District Planning and Budgeting" model developed in the Madison State Hospital District between this state hospital and its community mental health centers should be expanded to the other district state hospitals serving the mentally ill. There should be close linkages with area comprehensive health planning agencies, regional land use planning agencies, criminal justice regional planning organizations, area councils for the aged and other such planning agencies that plan on a sub-state level.

Summary

Staff development recommendations were made from ramifications of a forecast of the mental health delivery system for Indiana state mental hospitals in 1980. It was forecasted that the patient census at the state hospital will continue to decline. Assumptions used in the forecast were presented. The 1980 mental health system would be composed of well developed community services with much of their funds being generated by national health insurance. There will be an increased need to further develop the management capability of the state hospitals and community agencies. Staff development in clinical areas will also be stressed. The adult educator at either the Central Office level or at the state hospital needs to remember the social organizational characteristics of the new evolving mental health delivery system.


INDIANA STATE MENTAL ILLNESS HOSPITALS
Patients Enrolled
Patients Present
Dr. Norman M. Beatty Memorial Hospital
Larue D. Carter Memorial Hospital
Central State Hospital
Evansville Psychiatric Children's Center
Evansville State Hospital
Logansport State Hospital
Madison State Hospital
Richmond State Hospital
1967
1968
1969
1970
1971
1972
1973
1974
1975
FY


INDIANA STATE DEVELOPMENTAL DISABILITIES HOSPITALS
Patients Enrolled
Patients Present
Fort Wayne State Hospital and Training Center
Muscatatuck State Hospital and Training Center
New Castle State Hospital
Northern Indiana State Hospital and Developmental Disabilities Center
1967
1968
1969
1970
1971
1972
1973
1974
1975
FY

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Division of Planning and
July, 1975

Actual Patients Present
by
Indiana State Mental Hospitals, 1966-1975

	FY66	FY67	FY68	FY69	FY70	FY71	FY72	FY73	FY
MENTAL ILLNESS HOSPITALS									
Beatty-Civil	1,505	1,472	1,377	1,203	1,106	,081	810	935	
Beatty-MSD	494	494	501	339	307	280	218	146	
Carter	169	170	137	135	148	140	128	106	
Central	2,183	2,163	2,007	1,658	1,351	,065	968	734	
Evansville	932	910	890	832	751	707	676	621	
Logansport	2,081	1,956	1,830	1,694	1,500	,441	1,274	1,198	1,
Madison	1,268	1,230	1,164	1,099	1,008	921	858	786	
Richmond	1,418	1,375	1,193	1,052	946	844	669	636	
EPCC	-	19	20	21	24	22	18	19	
TOTAL	10,050	9,789	9,119	8,033	7,141	,501	5,619	5,181	4,
MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES HOSPITALS									
Fort Wayne	2,106	2,079	2,120	2,109	2,023	,938	1,645	1,399	
Muscatatuck	1,685	1,727	1,602	1,522	1,432	,439	1,330	1,261	1,
Northern Indiana	155	158	115	140	149	144	137	121	
New Castle	891	870	820	795	710	684	632	611	
TOTAL	4,837	4,834	4,657	4,596	4,314	205	3,744	3,392	3,
ALL HOSPITALS									
TOTAL	14,887	14,623	13,776	12,599	11,455	,706	9,363	8,573	

Actual and Forecasted Patients Present
by
Indiana State Mental Hospitals, 1974-80

Mental Illness Hospitals	Actual June, 1974	Actual October, 1974	June, 1975 Forecast	June, 1976 Forecast	June, 1977 Forecast	June, 1978 Forecast	June, 1979 Forecast
Beatty-Civil	780	745	700	700	675	675	650
Beatty-MSD	123	122	120	110	100	90	80
Carter	145	149	145	145	145	145	145
Central	652	677	650	650	650	650	650
Evansville	617	627	575	500	450	400	350
Logansport	1,081	1,026	900	800	600	500	450
Madison	699	735	675	650	500	425	375
Richmond	522	539	475	450	425	400	400
EPCC	17	25	20	20	20	20	20
TOTAL	4,636	4,645	4,260	4,025	3,565	3,305	3,120
Mental Retardation and Other Developmental Disabilities Hospitals							
Fort Wayne	1,247	1,238	1,175	1,100	1,100	1,050	1,050
Muscatatuck	1,210	1,212	1,100	1,055	805	695	665
Northern Indiana	92	93	90	90	90	90	90
New Castle	551	513	500	470	470	450	450
TOTAL	3,100	3,056	2,856	2,715	2,465	2,285	2,255
ALL HOSPITALS TOTAL	7,736	7,701	7,125	6,740	6,030	5,590	5,375
Error Percentage	-	-	2% (± 143)	6 ~~3~~% (± 202)	4% (± 241)	5% (± 280)	6% (± 323)
Error Range	-	-	6,982-7,268	6,538-6,942	5,789-6,271	5,310-5,870	5,052-5,6[illegible]

NATIONAL INSTITUTE OF MENTAL HEALTH
SERIES D, No. 4

Deinstitutionalization: An Analytical Review and Sociological Perspective

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND
MENTAL HEALTH ADMINISTRATION

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PREFACE

It is rare today to read a professional or lay article in the field of mental health that does not in some way depart from, allude to, and/or offer criticisms of or suggestions for implementing the deinstitutionalization of mental patients. Rarely defined in a precise manner, the very term deinstitutionalization evokes intense emotional and partisan responses. It is the verbal referent of a movement in mental health which has for over a decade preoccupied clinicians and researchers, citizens and politicians. The literature so abounds with articles concerning the various aspects of deinstitutionalization, that it would be very difficult indeed to present a systematic and coherent summary of all that has been written.

Originally, this work was intended as a summary review of the literature dealing with the issues in deinstitutionalization. As I began, however, to accumulate an ever-lengthening bibliography, it became clear to me that still another narrative review of issues could be of only marginal value; somehow, it seemed that it had all been said before. Gradually, but firmly, the recognition grew that both the deinstitutionalization movement and the literature that discusses it are plagued by a common problem: the absence of a clearly outlined theoretical framework. The more I began to understand the dimensions of this deficit, the more appropriate it seemed that the present study should in some way attempt to go beyond a mere enumeration-*cum*-discussion of the issues surrounding deinstitutionalization. It should, instead, have as its major purpose the attempt to tie together in a coherent and meaningful way those questions that have already been raised and those insights that have already been proffered, in the hope that such synthesis will lead to a kind of understanding that can be used by planners and program implementers of the future.

Accordingly, this work is to be regarded as an analytical review and theoretical synthesis of the *issues* in deinstitutionalization. It is not, *per se*, a comprehensive review of the literature. The bibliography is extensive, but it is not "complete." Because it would be extremely difficult, and probably not very productive, to include *all* deinstitutionalization references in the bibliography, I have selected for inclusion those writings—both professional and lay—which support or illustrate points I wish to make in the analytical review.

My training as a sociologist has predisposed me to interpret the literature in certain ways, and I have utilized some of the insights of other sociologists to help me formulate my theoretical conception of the issues in deinstitutionalization. I should like to make it clear, however, that I do not feel that a sociological approach is, *sui generis*, the correct way to view the issues. I feel, rather, that the deinstitutionalization movement should be studied from a variety of perspectives. It is such a complex phenomenon, that there must be many levels of productive analysis, and a sociological approach is but one of several possible frameworks. The basic consideration at this point is to stop looking at deinstitutionalization as if it is made up of discrete problems begging for rhetorical commentary and to start looking at it in a new way. The new perspective must represent an effort to understand *why* the many problems are occurring, and it must attempt to explain the interrelationships among these problems.

In summary, this work is to be regarded very much as a first step in the systematic understanding of the deinstitutionalization movement and of the issues that have surrounded it. In serving as a basis for future investigation, it will doubtless raise more questions than it answers. Hopefully, however, these new questions—unlike the old—will be of a kind that can be translated into action.

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Deinstitutionalization: An Analytical Review and Sociological Perspective

Leona L. Bachrach, Ph.D.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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I. INTRODUCTION

"There is a serious, one might even say schizophrenic, contradiction between two of the most important trends in present day community mental health. On the one hand there is a mass exodus of long-term psychiatric patients from the State Hospitals with the assumption that they will be cared for by community mental health programs. On the other hand, the trend in community mental health is toward programs which tend to exclude long-term patients, that is, intensive care programs with emphasis on crisis intervention."

—H. Richard Lamb, 1975

TOWARD A DEFINITION OF DEINSTITUTIONALIZATION

In a statement concerning deinstitutionalization, Bertram Brown (1975), the Director of the National Institute of Mental Health, has provided an operational definition of the term. He has described three essential components of deinstitutionalization: (1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment; (2) the release to the community of all institutional patients who have been given adequate preparation for such a change; and (3) the establishment and maintenance of community support systems for noninstitutionalized persons receiving mental health services in the community. Brown's statement is a description of an ideal. It expresses goals which, at this time, are still to be achieved. As a definition of what deinstitutionalization *should* or *might be*, it is an eloquent statement; as a definition of what deinstitutionalization *is*, it is still anticipatory.

In practice, the term deinstitutionalization is used in the literature to refer to a broad scope of patient-connected events, ranging from carefully planned local efforts to achieve the ideal expressed by Brown to the mass release of patients to communities as State hospitals have been "phased out" or closed. In some of the latter instances, patient release has been accompanied only by the most minimal pre-release patient preparation or planned community support. Almost always, in the literature, the term is used vaguely. Even some of the excellent treatises on the consequences of deinstitutionalization have failed to define it precisely. Sometimes the term appears to be used synonymously with "community mental health"—another movement which has paralleled the deinstitutionalization movement in time. Both have responded to the same social forces and are, in fact, philosophically very close relatives (Goldman 1976). However, the community mental health movement is broader in scope, for it concerns, in addition to the treatment of the noninstitutionalized mentally ill, the treatment of other individuals who would not be considered potential candidates for institutionalization (Dinitz and Beran 1971; Simon 1975). The community mental health movement is also concerned with providing a range of indirect services, aimed at the prevention of mental illness, which are not ordinarily considered to be within the scope of traditional activities conducted at mental hospitals (Wagenfeld 1972).

For purposes of the present study, deinstitutionalization may be understood as a process involving two elements: (1) the eschewal of traditional institutional settings—primarily State hospitals—for the care of the mentally ill, and (2) the concurrent expansion of community-based services for the treatment of these individuals. There are, actually,

two components of the deinstitutionalization process: the removal of persons who have already been hospitalized from their institutional environments and their transfer into the community; and the prevention of hospitalization of those persons who might be considered potential candidates for institutionalization.

Deinstitutionalization is, however, more than a process concerned with the locational aspects of patient care. It is also the expression of a philosophy rooted in an era of social and political reform which strongly emphasizes peoples' self-determination and their right to control the forces that affect them (Hersch 1972). It is important to understand this aspect of deinstitutionalization. Were only the locational aspects of patient care at issue, the movement might have caused only a minimum of controversy which could be relatively easily negotiated and resolved. But the movement in fact calls for very basic and fundamental changes in patterns of life deeply embedded in the American culture. Because of this, deinstitutionalization has "become the focus of an emotional debate" (Anonymous 1975*e*), which is characterized by polarized attitudes and resistance to compromise.

A SOCIOLOGICAL PERSPECTIVE ON DEINSTITUTIONALIZATION

Brown (1975) has pointed out that "the very term deinstitutionalization has become controversial, with conflicting connotations in different contexts" and that perhaps "the time has come to look for more appropriate terms." The present study, however, adopts a different position. The vagueness of the term notwithstanding, deinstitutionalization is connotative of a sociological process, and, in this sense, it is on mark. The sociologist, Kingsley Davis (1949, p. 71), has defined an institution as a "set of interwoven folkways, mores, and laws built around one or more functions." In short, an institution may be viewed in two different ways: as an established *place*, such as a long-term care mental hospital, or as an established *set of social patterns*, such as the totality of artifacts and practices society has adopted for the care of its mentally disabled population. It is in the latter sense that the term deinstitutionalization, when used in reference to the mentally ill, has greatest value. It implies the breakdown of a social system, of established patterns of social control which determine how the mentally ill should be viewed, what their status (position) in society is, what rights and obligations society has in reference to them, and what rights and obligations they have in reference society.

In the present study, the terms institution, institutionalization and deinstitutionalization will be used primarily in the popular sense—that is, to refer to movements of patients in and out of mental hospitals. However, the terms will also be used at times in the sociological sense, as the author knows of no alternative terminology which conveys quite the same meaning. The specific usage of these terms should be apparent from the context in which they occur.

SCOPE OF STUDY

This study proceeds from the basic assumption that the promise of the deinstitutionalization movement—i.e., the enhancement of mental health services delivery through the provision of community-based facilities—can best be realized if the problems which it has encountered are recognized and acknowledged. Only through such appraisal can the problems be overcome. The basis for this work is a review of the literature concerned with the deinstitutionalization of mental patients. That review has resulted in the author's adoption of the position that not enough theoretically systematic attention has been paid to the process of deinstitutionalization. This has generated serious obstacles to the understanding of the process and of the issues related to it. Without a theoretical framework, writings have tended to contain, for the most part, a jumble of disparate facts and guesses, interspersed with strongly worded partisan stands. The resultant confusion has been sufficiently overwhelming to be counter-productive. Instead of receiving constructive criticism directed toward resolving issues in a practical way, the movement has found itself bogged down by seemingly insoluble problems.

It is the purpose of this work to describe the issues in deinstitutionalization concisely and systematically and to examine them with the assistance of a theoretical framework. The framework to be used is functionalist in nature and is based on insights provided by an anthropologist (Malinowski 1945), a semanticist (Hayakawa 1949), and several sociologists (Chinoy 1954; Crawford 1973; Johnson 1960; Merton 1957). A fundamental and underlying assumption is that many of the problems connected with deinstitutionalization are closely

related to a general failure, first, to understand and/or pay adequate attention to the unique position of the mental hospital in American culture, and, second, to make sufficient allowances for this uniqueness in the process of planning for social change.

At the conclusion of the text is a bibliography of citations from the professional and lay literature dealing with deinstitutionalization of the mentally ill and related topics. In no sense is this bibliography intended to be "complete." The body of literature is so vast and has taken such a variety of directions that any effort to include all writings would be doomed to failure. This study does, however, aim at reviewing broadly and summarizing generally the major issues treated in the literature. To this end, selections have been included in the bibliography for their relevance to points made in the text. Citations have generally been limited to writings from the past decade, but occasional earlier works have also been included in instances where they are especially relevant to, or strongly reinforce, particular points under discussion. In addition, a number of references not dealing with deinstitutionalization *per se*, but relevant to the sociological analysis of the materials reviewed, have been included in the bibliography.

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II. BACKGROUND

"Characteristic of each humanitarian movement are four distinct periods. The first is a period of innovation or new ideas. This peaks rapidly after the initial outburst of enthusiasm, as the community mental health movement did between 1965 and 1970. The peak is followed by a period of criticism and then a time of retrenchment. The four periods are thus innovation, peaking, criticism, and retrenchment."

—Trevor D. Glenn, 1975

Recent years have witnessed the gradual phase-out of a number of mental hospitals and the complete closing of others,[1] while the utilization of local community-based services has steadily increased. That there has been a growing trend toward the treatment of the mentally ill in their home communities is apparent from utilization statistics. In 1955, about half of the psychiatric patient care episodes in the Nation were in State mental hosptals, as contrasted with about one-fifth in 1971. Outpatient services accounted for only 23 percent of psychiatric patient care episodes in 1955 but for 42 percent in 1971. Federally funded community mental health centers, which did not even exist prior to the passage of the Community Mental Health Centers Act of 1963, accounted for 19 percent of psychiatric patient care episodes in 1971 (Pollack and Taube 1975; Redick 1973).

Paralleling the reduction of patient care episodes in State hospitals has been a dramatic decrease in the size of State hospital resident populations. The number of resident patients in State mental hospitals, which peaked at 558,992 in 1955, has been decreasing ever since. During a period of 9 years alone, starting with the 1963 Presidential message on mental health, the resident population of State hospitals decreased by 45 percent (from 504,604 to 275,995). One of the critical elements in this decrease has been the smaller number of first admissions aged 65 and over and the correspondingly heavier reliance on nursing home and other residential facilities for this long-stay population. Another factor has been the widespread use of psychoactive drugs in the treatment of inpatients, which has made possible greatly shortened hospital stays, as well as the release of patients who might never otherwise have been considered for discharge into the community.

At the same time that the resident population of State hospitals has decreased in size, the number of admissions to these hospitals has, in general, increased.[2] Thus, more patients have been admitted for shorter periods of time. Although the general diagnostic distribution of the resident population at these institutions has not changed appreciably over these years—about half the resident patients have been and continue to be schizophrenic—there has been a marked change in the diagnostic composition of admissions. In 1962, for example, 21 percent of first admissions to State hospitals had diagnoses of schizophrenia, and 15 percent had diagnoses of alcohol disorders. In 1972, corresponding percentages were 14 percent and 26 percent, respectively.

[1] A number of references describe and discuss phasedowns, phaseouts, and closings of State hospitals. Selected examples are: Cumming and Markson (1975): Ishiyama (1974); Keenan (1974); Khan and Kaplan (1974); Markson (1976); Markson and Cumming (1974); Marlowe (1974); McDonald (1974b); Place and Weiner (1974); Schultz, Lyons and Nothnagel (1975); Sills (1975); State of California (1973); Weiner, Bird, and Associates (1973).

[2] Actually, with the year 1972, a reversal in statistical trends is noted. Taube (1974) reports that admissions to State mental hospitals during both 1972 and 1973 showed decreases over the previous years.

These statistics reflect a changing philosophy of mental health care in the United States—a philosophy which, in recent years, has undergone rapid and major revision. Outpatient care has been favored over inpatient treatment. And when inpatient treatment has been indicated, the emphasis has been in the direction of care in short-term facilities, such as general hospitals and community mental health centers, instead of long-term mental institutions.

There has been a growing conviction among many mental health professionals that the removal of the mentally ill individual from "normal home and community ties" (Schwartz 1971) reduces his chances for effective treatment. Thus, the new philosophy in mental health care embraces the goal of avoidance of hospitalization whenever possible and the "replacement of custodial philosophies by therapeutic ones" (Schwartz 1971). Because institutionalization is perceived as "banishment" (Rusk 1972)—because it is viewed as fostering regression among patients (Herz 1972)—there is a strong feeling that the provision of services on any basis other than institutionalization is superior to a hospital experience. Although access to adequate mental health services is understood to be a basic right of all individuals, these services should, ideally, be provided without exposing patients to the stigma associated with traditional custodial mental health care. In addition, the noninstitutionalized patient living in the community has the opportunity to benefit from the salubrious effects of social contact with sympathetic and supportive relatives and friends (Kramer 1967).

These philosophical principles, coupled with evidence that "hospitalization begets more hospitalization" (Schwartz 1971),[3] lead logically to a strong commitment to the notion that the role of the mental hospital in the treatment complex must be revamped, if not eliminated. With patient care occurring in a familiar, relatively stigma-free home environment, the patient is more likely to be understood and to see himself as a participating member of his own home community, rather than as a stigmatized expatriate.

This entire philosophy is thrown into sharp relief by an emerging development—the introduction of so-called brief hospitalization units for psychiatric patients in some localities (Caffey, Galbrecht, and Klett 1971; Herz, Endicott, and Spitzer 1975; Rhine and Mayerson 1971; Schwartz 1971; Schwartz, Weiss and Miner 1972; Walker, Parsons and Skelton 1973; Yarvis 1975). Typically, these units are administratively connected with emergency services in general hospitals, although they may be tied to other services. They admit patients for brief stays rarely exceeding 4 or 5 days, during which a judgment is made regarding further disposition of the case—that is, discharge or transfer to an inpatient facility. Patients who are discharged directly from these units may to some extent avoid the stigma associated with psychiatric hospitalization, as they frequently are technically not counted as having occupied psychiatric beds.

Changes in service delivery philosophy have, of course, not occurred in an ideological vacuum. To the contrary, they may be understood as having had what might be called a natural history of their own: they have come about as logical responses to what may simply be labelled "the times." Feldman (1974) aptly points out that changes in treatment patterns have occurred "not because our patients are really any different, but because we are." In short, there has in recent years been a strong civil libertarian emphasis on the rights of mental patients (Schmolling 1975; Slovenko and Luby 1974).

Hersch (1972) provides a penetrating discussion of the ideological bases of deinstitutionalization.[4] He points out that, typologically, "the times" may be characterized in one of two ways—either as an era of social-political conservatism or as an era of social-political reform. The former favors a view of problems as having their bases in individuals, while, in the latter, the locus of problems is the environment. Accordingly, in the former case, emphasis for amelioration is on changing the individ-

[3] There is a substantial amount of statistical evidence for this generalization. Selected examples are provided in: Anthony et al. (1972); Buell and Anthony (1973); Fontana and Dowds (1975); Franklin, Kittredge and Thrasher (1975); Rosenblatt and Mayer (1974). Kirk (1976) provides an interesting perspective on readmission statistics in his report of a study of Kentucky State hospital dischargees. He finds that patients receiving no aftercare community services and those receiving substantial aftercare community services are the least likely candidates for readmission. He concludes: "Aggregating all of those who received aftercare apparently obscures the fact that those who receive some, but not much, aftercare, are the ones with the highest readmission rate."

[4] Selected additional references which amplify the ideological forerunners of the deinstitutionalization movement are: Felix (1964); Joint Commission on Mental Illness and Health (1961); Macht (1974); Rubins (1974*a*); Scherl (1974); Schwartz and Schwartz (1964).

ual; in the latter case, greater weight is placed upon modifying the environment.

The deinstitutionalization movement is clearly the outgrowth of an era of social-political reform. Greenblatt (1975) writes of the "rise of social psychiatry" during the second half of this century, which is reflected in "planning for ways and means of serving all the citizens ... without regard to race, color, creed, or ability to pay." To illustrate Greenblatt's point, consider this quotation from a recently released position paper prepared by the Director of the Horizon House Institute (Rutman 1976, p. 2):

> Several basic issues underlying the concern for community-based—as opposed to institutional—care for the mentally disabled should be noted at the outset. First, a major proportion of all persons now in mental institutions, or those who will be hospitalized in the future, neither need nor benefit from long-term extended inpatient care. Second, there is reliable evidence that patients who remain in institutions for extended periods experience a variety of debilitating effects, and that the cumulative results of long-term confinement—a condition or state often referred to as institutionalization—is more damaging to the individual's mental health and well-being than the problem which required entering the hospital in the first place. Finally, for large numbers of present and future hospital patients, return to normal social functioning can only be accomplished if there are developed a variety of community-based residential facilities which can provide an atmosphere in which such persons can feel secure and accepted by peers, can improve skills of daily living, and can be helped to find their niche in the normal environment.

However, dominance of a reform ideology in a democracy does not preclude the strong co-existence of a conservative ideology. Steinhart (1973), in pointing this out, asks whether the pendulum may not have swung too far in the direction of community care. He writes:

> The original theme of keeping patients at home whenever possible has become ritualized into keeping patients completely out of the state hospitals, and even keeping them out of *any* mental hospital. Unfortunately, there are times when patients need to be hospitalized, whether in a state hospital or elsewhere.

Rieder (1974) states:

> The State mental hospital system, and the patients in it, are in danger of being "phased out" without an effective alternative source of care being available. It is a ridiculous abrogation of our responsibility if psychiatrists and other mental health professionals allow the existing poor treatment of mental patients to be replaced with something even worse.

POLARIZATION: OPPOSING VIEWS

The most cursory examination will show that the literature abounds with horror-story descriptions of the conditions of life inside mental hospitals. Not only have the physical conditions in these places been assailed, but so has the intense deliumanization—the "feeling that one is isolated from others and is regarded as a thing rather than as a person" (Leventhal 1975, p. 20)—experienced by the patient. Perhaps more penetratingly than any other recent writer, Rosenhan (1973), in summarizing the experiences of eight pseudopatients at 12 different mental hospitals, has painted a grim verbal picture of the depersonalization experienced by the patient in the mental hospital:

> Powerlessness was evident everywhere. The patient is deprived of many of his legal rights by dint of his psychiatric commitment. He is shorn of credibility by virtue of his psychiatric label. His freedom of movement is restricted. He cannot initiate contact with the staff, but may only respond to such overtures as they make. Personal privacy is minimal. Patient quarters and possessions can be entered and examined by any staff member, for whatever reason. His personal history and anguish is available to any staff member (often including the "grey lady" and "candy striper" volunteer) who chooses to read his folder, regardless of their therapeutic relationship to him. His personal hygiene and waste evacuation are often monitored. The water closets may have no doors.

Rosenhan continues, "At times depersonalization reached such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account," and provides this episode to illustrate his point:

> A nurse unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men. One did not have the sense that she was being seductive. Rather, she didn't notice us.

Similarly, one finds damning descriptions of the plight of deinstitutionalized mental patients who are residing in the community. A strongly worded

and urgent statement is presented by Slovenko and Luby (1974)[5]:

> Mental patients are going from the frying pan into the fire. Under the guise of civil liberties the state mental hospital has been transported to the inner city. It is true that many persons in institutions have been dehumanized through neglect and the failure of society to meet their needs, but the second wrong of turning them back into a so-called community will not make a right. In today's world, neglect in the community dwarfs neglect in hospitals.

An example of what Slovenko and Luby mean is described in a paper by Wolpert, Dear and Crawford (1974), who write about the fate of deinstitutionalized patients in a section of San Jose, California, where approximately 10 percent of the population is composed of "discharged patients who are indolent and living in board and care facilities." The authors state:

> While there is little or no evidence to suggest that the residents are mistreated or exploited by the operators [of the 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. Some of those who are employable have found employment or do become involved in county, religious, university or other volunteer programs which have been set up for their use. They may be seen walking in the streets, sitting in the laundromat or cheap cafes, and some are recognizable by the characteristic "drug shuffle," bowed head and shabby appearance.

Other writers—for example, Anderson (1974); Becker and Schulberg (1976); Chu and Trotter (1974); Greenblatt and Glazier (1975)—report evidence of financial exploitation of expatients by community caretakers with whom they come into contact.

In short, the deinstitutionalization movement has, since its inception, been characterized by a polarization in attitudes—a process not unusual in circumstances where social change involves issues with emotional overtones. A description of the polarization process is found in sociological theory:

> Necessarily public issues tend to be phrased in dichotomous terms—e.g., war or peace, protection or free trade, prohibition or saloons, freedom or slavery. This does not mean that each problem has only two facets but simply that public action can best be mobilized, a denominator most easily struck, when there are only two sides. The most common formula is the "for or against" statement. . . Often the individual is not on either side in a completely unqualified sense, but the heat of public debate and the necessity of mass action reduce the problem to its lowest common denominator, the simple dichotomy. Each pressure group tries to phrase the issue in a way that will marshal sentiment on its side. . . The final solution of the issue is often one that practically nobody actually desires but which represents the ultimate outcome in the struggle of conflicting pressure groups—a struggle in which the weapons of distortion, intimidation, censorship, misinformation, and irrelevancy play important parts. (Davis 1949, p. 359.)

Thus, Reding (1974) expresses this polarized view in a letter to the *Psychiatric News*:

> The rehabilitation of human warehouses, euphemistically labeled "state hospitals," is a hopeless task, thank God. Adding good psychiatrists to such institutions is like pouring good wine into a bad barrel. . . There is only one way to deal with state hospitals or, for that matter, with prisons: empty them, close them, then blow them up, because, as is well known, state legislators cannot tolerate empty buildings. Then only shall we psychiatrists be cornered into honoring our Hippocratic oath and our social obligations. Then only can we be expected to go help the local communities take care of their own human problems instead of storing them out of their sight and ours.

And Mendel (1974*a*), in a paper presented at a conference on the closing of State mental hospitals, concludes with this statement:

> Since the hospital as a form of treatment for the severely ill psychiatric patient is always expensive and inefficient, frequently antitherapeutic, and never the treatment of choice, it behooves us now to develop a strategy and time table for dismantling the mental hospital.

Dingman (1974) counters with these observations:

1. State mental hospitals ought never to have been established.
2. They do exist and we have encouraged dependence upon them.

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[5] Additional selected references detailing the plight of deinstitutionalized mental patients in the community include: Allen (1974); American Federation of State, County, and Municipal Employees (1975); Anonymous (1975*b*); California State Employees' Association (1972); Chase (1973); Crane (1974); Davenport (1974); Lamb (1975); Malloy (1974); Reich (1973); Reich and Siegel (1973); Saltzman (1975); Sheppard (1976); Slovenko anl Luby (1975); Trotter and Kuttner (1974).

3. Suitable facilities to which to transfer the dependence do not exist at this time.
4. CCMHC's [comprehensive community mental health centers] are inheriting many of the defects of state mental hospitals and, therefore, there is little point in planning to transfer functions to them.
5. Closings on any major scale are unthinkable.

DEPOLARIZATION: MODERATION OF VIEWS

It is really only in the very recent literature that substantial tempering of polarized stances begins to become noticeable. Although, of course, some earlier writers adopted moderate viewpoints, it is primarily in the literature of the mid-1970's that the compromising of extremes has become dominant. It is now increasingly recognized and acknowledged that earlier diatribes against mental hospitals might have been unfair simply in their failure to acknowledge that these facilities do not necessarily nor uniformly fit the grim picture of dehumanization described earlier. In addition to what may be characterized as humane care, many mental hospitals, in fact, offer innovative and experimental programs and some provide as complete a range of services as those found in community mental health centers (Horizon House Institute 1975*b*; Jones 1975; Kedward et al. 1974; Kramer and Taube 1973; Lando 1976; Rosenblatt and Mayer 1974; Schapire 1974; Stubblefield 1976*a*; Texas DMHMR 1976).

Now, instead of partisan statements seeking to denigrate all alternatives, a continuum of treatment alternatives is proposed. Now, statements that acknowledge frankly that the world of mental health services has a place for both institutional and community-based facilities are becoming popular, and there is a strong call for co-existence. Barnett (1975, pp. 274–275), speaking more globally of health services in general, states that there must be:

> . . . a variety of approaches in health delivery to meet the variety of responses in the population to be served. The question no longer is: "How can we humanize the system?" Rather, it is: "What is the best procedure for what kind of patient?" Once there is variety, informed choice becomes possible for the patient. We should not fall into the trap of prescribing a new monolithic system for the present, no matter how "humanized" the new system may appear. A monolithic system (i.e., one without variety and choices) cannot be a humanized system.

This view is clearly shared by many concerned specifically with mental health services. The Executive Committee of the American Psychiatric Association has released a position statement declaring the need to retain chronic care facilities (Anonymous 1974*b*):

> While we applaud the trend toward the growing adequacy of community resources and the concurrent reduction of the patient population in public mental hospitals, we now view with considerable concern the trend toward the phasing out of the capacity for providing long-term inpatient care and treatment for the mentally ill or disabled.

The APA statement cites as a major reason for this position that "pressure to discharge patients from the public mental hospital too often results in discharging patients without adequate planning, which in turn results in their living in substandard and dehumanizing circumstances." A Senate Select Committee of the California Legislature has sought to abandon earlier plans to phase out all State mental hospitals; it is now proposed that hospitals be integrated into local service delivery systems (State of California 1974).

De la Torre (1973) points out that "one should keep in mind that prevention of hospitalization is a means and that the prevention or amelioration of psychiatric illness is the real end." Nowhere is the newly emerging broad awareness of the need for a range of services including the mental hospital better expressed than in a paper presented by the British psychiatrist, John Wing (1975):

> The quality of life lived by the patient and his relatives is the final criterion by which services must be judged. A good hospital is better than a poor hostel or a poor family environment. A good family environment is better than a poor hospital or a poor hostel. The same may be said of day-time environments—open employment, enclaves in ordinary commercial business, rehabilitation or sheltered workshops, or protected day centers. Universal denunciation of any one type of setting is likely to be harmful since it is clearly not based on rational principles of assessment, treatment or care.[6]

Current writings on deinstitutionalization appear also to be considerably less emotional in tone than the earlier treatises. Now, some of the affect

[6] Selected additional references illustrating the emerging depolarization in viewpoint include: Mechanic (1975*b*); Ochberg (1975); Reich and Siegel (1973); Smith and Hart (1975).

has been tempered by practical experience. Whereas earlier statements were based on untested assumptions, and "oversimplifications served as the rocks upon which programs were sometimes hurriedly built" (Black 1974), today's viewpoints are grounded in a decade and more of reality (Goldman 1976). The deinstitutionalization movement now possesses a history, however brief (Anonymous 1976*d*), and many current positions are the result of experience.

III. SUMMARY OF ISSUES IN DEINSTITUTIONALIZATION

"But what kind of crusade is it to condemn sick and fearful people to shift for themselves in an often hostile world; to drag out, all too commonly, a hungry and derelict existence in a broken-down hotel if they are lucky; victimized, if they are not, by greedy operators of so-called halfway houses that are sad travesties on a fine concept? All without their even knowing the possibilities of new medical approaches to their illness—and all in the name of civil liberty."
—*New York Times* Editorial, April 8, 1975

Four recent articles appearing in journals have, in the view of this author, contributed greatly to summarizing the issues in deinstitutionalization and elucidating the critical nature of these issues. A very readable work by Kirk and Therrien (1975) examines issues in deinstitutionalization with a view toward exposing the "myths" which have surrounded the movement. A second article, by Greenblatt and Glazier (1975), serves further to amplify issues by focusing on some of the shortcomings in treatment at community-based facilities and on the general paucity of information available on which to base program plans. This reference is especially valuable for its clarity. A third article, by Becker and Schulberg (1976), appears in a nonpsychiatric medical journal. Entitled "Phasing Out State Hospitals—a Psychiatric Dilemma," its very placement in the coveted "Special Article" spot in the prestigious *New England Journal of Medicine* attests to the importance of the deinstitutionalization movement. This reference underscores the fact that the controversy concerning deinstitutionalization is no longer confined to the fraternity of mental health workers, nor even the popular press; even the greater medical community now feels constrained to review the issues. Finally, a sociological "case history" of a single State hospital (Fowlkes 1975) provides insights into the "structured resistance" to change in the world of mental health service delivery.

Together, these four articles give to the deinstitutionalization movement a well-deserved aura of importance and immediacy. They say, in no uncertain terms, that: (1) the issues in the deinstitutionalization movement are manifold, complex and serious; (2) the issues cannot be resolved by rhetoric; and (3) the time has come to evaluate these issues on a conceptual level in order to make them more comprehensible and more responsive to ameliorative efforts.

It is not the intention of the present study to rehash the issues in deinstitutionalization in detail. This has been done frequently, and often with great skill; and doing so here would merely be repetitious. It is, however, important to present some kind of taxonomy of these issues, short of detailed elaboration. This the present work attempts to do. Such an endeavor is by its very nature selective. So many complex problems have been cited, and there is so much overlap, that the mere selection, enumeration, and ordering of problems must reflect the biases of one who classifies them. Their specific ordering here results from the theoretical perspective employed, which will be detailed in the next section of this study.

The issues summarized here will be presented concisely. References to citations which amplify them will be provided. In addition to those issues which are dealt with directly in the literature, this study will discuss other issues, rarely labelled as such but apparent from a review of current writings —sometimes as much from a lack of systematic attention (as in the case of the problem of the views of institutionalized patients themselves toward deinstitutionalization) as from an examination of the elements involved.

A TAXONOMY OF THE ISSUES IN DEINSTITUTIONALIZATION

The issues in deinstitutionalization appear to fall into eight major groupings as follows: Issues related to the selection of patients [7] for community care; issues related to the treatment course of patients in the community; issues related to the quality of life of patients in the community; issues related to the greater community; financial and fiscal issues; legal and quasi-legal issues; informational issues; and additional issues resulting from the process of deinstitutionalization itself.

It cannot be too strongly emphasized that the issues presented here are separable only in theory. They are completely intertwined, and artificial separation of them at this time is made only for taxonomic purposes. Their ubiquitous interdependence should become apparent to the reader as he proceeds through the narrative supporting the catalogue of issues. In short, the system of care of the mentally ill in this society is institutionalized (in the sociological sense) and hence is characterized by an integration of its elements. Any specific element in the system is in many ways and by a variety of routes related to any other element, and a change affecting one element precipitates changes in all others. Thus, whether a specific problem in the deinstitutionalization movement—such as the limitations on physical mobility which many patients experience in the community—is classified under the second, third, fourth, or some other category mentioned above is a moot question. Theoretically, the problem belongs in all categories, and the specific assignment on paper is a matter of the author's discretion in judging where its placement seems to be most apt.

THE ISSUES EXAMINED

I. Issues related to the selection of patients for community care:

A. *Chronically ill patients*—According to Mechanic 1975*b*, p. 5), "one of the adverse consequences of the expansion of mental health concepts in the 1960's was the redirection of attention from the needs of the psychotic patient. . . Community mental health centers had diffuse missions and found it easier—and perhaps professionally more rewarding—to focus on assistance for those with less severe disorders." Kirk and Therrien (1975) write of their concern for "the fate of a specific group of patients: those who would have been or would be likely candidates for long-term hospitalization but who, because of the decline of the state mental hospital, are now residing elsewhere." The needs of chronically ill patients are often ignored in the community, partly because such patients tend to be viewed as what Kirk and Therrien (1975) call "an undesirable clientele," and partly because the facilities needed for treating them are lacking. Lamb (1975) asserts that most mental health professionals resist working with long-term patients in the community as the result of unwarranted bias.[8]

B. *Patients inadequately prepared for life in the community*—Place and Weiner (1974, p. 46) report from a followup study of patients released from Napa State Hospital in California, that "the most glaring deficiency of mental health services is the lack, if not total absence of programs designed to provide discharged patients with the practical skills needed to function in an ordinary community." Similarly, Anthony et al. (1972) conclude that although "inpatient treatment innovations improve the patients' in-hospital behavior . . . the research does not indicate that these approaches can singularly effect posthospital adjustment." Since long-term chronic care tends to "foster social and economic dependence" (Roth 1970, p. 61), it "creates norms and behaviors which reinforce the dependent role of the patient, [and] these behaviors are frequently at odds with those needed to survive successfully in the community" (Rutman 1976); re-entry into the community may thus prove extremely problematic for some former patients (Jansson 1975). Adjustment may require the establishment of "meaningful new social statuses" defining the position of former patients in the community (Sanders 1974). Stubblefield (1976*b*) refers to a related problem: placement of rural patients in urban aftercare settings as the result of "limited to nonexistent" resources in their home communities. Such "transplants" experience heightened psychological and social burdens in rehabilitation.

C. *Disadvantaged and minority groups*—Weclew

[7] "Patients" for purposes of this study are loosely defined as 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.

[8] Numerous references deal with the plight of chronically ill patients in the community. Selected examples include: Becker and Schulberg (1976); Crane (1974); Falk and Murphy (1976); Hogarty (1971); Lamb (1976*a*); Reich (1973); Reich and Siegel (1973); Whittington (1969).

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(1975) contends that community-based services tend to be irrelevant to the needs of Latino patients and that this results in their underutilization of such services. Mayo (1974) points out similar problems in the community treatment of blacks. Other studies deal with difficulties in providing relevant treatment to rural patients,[9] to elderly patients (Anonymous 1976*f*; Becker and Schulberg 1976; Flashner, Engadela and Alderman 1974; Hicks 1976; Muskie 1974; Redick 1973), and to patients of low socioeconomic status. Myers and Bean (1968) assert that "adjustment in the community is most difficult for lower-class patients." A common denominator in these observations dealing with disadvantaged and minority groups appears to be that community treatment needs to be tuned in to the cultural needs of the patients which it serves. It must be more aggressive than hospital-based treatment: patients in the community must be attracted in such a way that they will voluntarily utilize the facilities.

II. Issues related to the treatment course of patients in the community:

A. *Inadequate range of treatment services*—The range of treatment services available to patients in the community must be expanded and elaborated (Rutman 1976). Kirk and Therrien (1975) indicate that there is a "lack of knowledge about what would constitute an effective and inexpensive treatment [for former mental patients] . . . The only partially effective treatments are the psychotropic drugs, but these are clearly only a first step." Rosenblatt (1975) proposes the formation of nontherapy-oriented custodial care facilities in the community. Rouslin (1975), however, argues for more direct patient treatment which "is not even a part of some community mental health programs." Allen (1974), a former patient, writes:

> Regardless of what treatment programs exist in the community, they surely are not providing *enough* therapy. I myself see many, many people who, so far as I can tell, are untouched by anything that resembles treatment. . . I believe the majority of board and care residents live in an isolated, removed, seldom-changing, untouched world. There is a very real possibility that yesterday's back wards of State mental hospitals are becoming today's board and care homes.

B. *Fragmentation and lack of coordination in community treatment services*—Community-based mental health services are frequently lacking in centralized administration, and this results in fragmented responsibility. Relevant agencies do not have open lines of communication. Kirk and Therrien (1975) suggest that community-based services need to have "a single agency or person acting as sole agent or advocate for the patient or having primary responsibility for seeing that . . . [his] many needs are adequately met." The issues of fragmentation and lack of coordination are among the most widely and heatedly discussed in the literature. Selected references dealing with these issues include: Gittelman (1974); Grenny and Crandell (1973); Horizon House Institute (1975*b*); Rutman (1976); Zehr (1969).

C. *Inaccessibility of treatment services*—Community services may prove to be less accessible to mental patients than hospital-based services in a variety of ways—e.g., limited business hours at service facilities, or greater time, distance, and financial resources required to travel to such facilities. Feldman (1974) lists three components of accessibility: geographic, financial, and psychological. With respect to psychological accessibility, it is necessary that community care be aggressive; it cannot be assumed that because treatment facilities exist, patients will automatically utilize them (Davis, Dinitz and Pasamanick 1972). Discussions of accessibility issues are found in Feldman (1971), Mannino, Rooney, and Hassler (1970), and Mechanic (1975*a*).

D. *Questionable quality of care in community services*—The limited range of available services, the fragmentation of services, the inaccessibility of services—as well as the precipitate manner in which community service networks have sometimes come into being—combine in such a way as to raise serious doubts concerning whether patients are getting optimal treatment (Allen 1974; Hoshall and Friedman 1975). Special objections have been raised by some writers to what is considered disproportionately heavy reliance on psychoactive drugs—sometimes to the exclusion of other treatment modalities—in the community. See, for example, Crane (1974), and Scheff (1976).

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[9] Numerous references deal with the special needs of mental patients residing in rural areas. Selected examples include: Bentz, Edgerton and Hollister (1971); Brown and Taylor (1966); Buxton (1973); Cody (1973); Edgerton and Bentz (1969); Gertz (1974); Gertz, Meider and Pluckhan (1975); Greene and Mullen (1973); Guillozet (1975); Gurian (1971); Hollister (1973); Kraenzel and Macdonald (1971*a*); Kraenzel and Macdonald (1971*b*); Lee, Gianturco, and Eisdorfer (1974); Procter (1973); Taylor (1973); Torino (1975).

III. Issues related to the quality of life of patients in the community:

A. *Inadequate community support systems*—For all persons, "successful functioning depends on the material assistance and emotional support we receive from our fellows" (Mechanic 1975*a*). Such supports are frequently unavailable to mental patients residing in the community, often as the result of the very special psychological and interactional difficulties that characterize them. "Without well-organized and aggressive [community support] services . . . patients are often lost in the community and eventually end up in difficulty" (Mechanic 1975*b*). Accessibility is also a problem in community support systems. These systems are needed to assist noninstitutionalized patients in those areas of life where friendly intervention and a helping-hand are frequently needed—e.g., the development of friendship networks, the seeking out of employment opportunities, and the organization of leisure and social activities. Sometimes support systems are needed to assist patients in areas related to treatment—e.g., in setting up of appointments and transportation to therapy sessions.

B. *Residential facilities and living arrangements*—"The first obstacle faced by every state hospital system which wants to close down is what to do with the large number of patients currently hospitalized, some of them hospitalized for many years. Many of these patients have neither family who want them nor financial or social resources to secure adequate housing" (Kirk and Therrien 1975). Clearly, noninstitutionalized patients cannot always live "at home." Kramer (1970) outlines these underlying assumptions which are "central to the expectation that patients can be kept in their homes":

> (1) Patients have a home. (2) Patients have a family or other persons who are willing to assume responsibility for them and are well enough and financially able to provide the necessary care. (3) Patterns of organization and interpersonal relationships in the patient household are such as not to impede or prevent the recovery or rehabilitation. (4) The family has sufficient understanding of the patient's illness and expected behaviour so as to develop attitudes which assist rather than retard recovery and rehabilitation. (5) The patient's behaviour and his needs are such that his presence in the household does not produce undue hardships for the other members of the household and does not precipitate secondary attacks of disease and disability in the other members. (6) Appropriate medical, psychiatric, nursing, social work and related services are readily accessible to meet the changing needs of the patient and his family.

Although the various alternative living arrangements such as halfway houses, homes for the aged, boarding homes, nursing homes, residential hotels, etc., which have been designed for the housing of mental patients in the community, have often [in specific instances] been found adequate and even preferable to hospital residence, most reports indicate that on a widespread basis they usually have fallen short of the desired goal of providing a humane environment.[10]

IV. Issues related to the greater community:

A. *Community resistance and opposition to mentally ill individuals*—This is a much discussed issue in the literature. There appears to be consensus that society has difficulty in dealing with the presence of mental patients in their midst. Kirk and Therrien (1975), in discussing patients discharged from mental hospitals, summarize the position: "Former patients are not welcomed back into communities with open arms; instead they are often confronted by formal and informal attempts to exclude them from the community by using city ordinances, zoning codes, and police arrests." They conclude that "Residence 'in the community' can be just as disabling, frightening, dehumanizing, and isolating as living in the back wards of more formally structured institutions."[11]

B. *Effects on communities to which patients are released*—In urban areas, services for deinstitutionalized mental patients tend to be concentrated in certain neighborhoods, and "a highly visible and significant new problem has evolved . . . in the selective concentration of a variety of service fa-

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[10] Numerous references deal with the problems of living arrangements and residential facilities within the community. Selected examples include: Bachrach (1975*b*); Brodsky (1968); Cumming (1975); Davis, Dinitz, and Pasamanick (1974); Deasy and Steele (1976); Edelson (1976); Heinemann, Yudin, and Perlmutter (1975); Kramer and Taube (1973); Lamb and Goertzel (1971); Mannino and Shore (1975); Miller (1970); Muskie (1974); Robbins and Robbins (1974); Schulberg, Becker, and McGrath (1976); Sheppard (1976); Thompson (1975).

[11] Numerous additional references deal with the issue of community resistance and opposition to mentally ill persons. Selected examples include: Anonymous (1976*g*); Aviram and Segal (1973); Farina et al. (1974); Greenblatt and Glazier (1975); Horizon House Institute (1975*b*); Lowinson and Langrod (1975); Ochberg (1974); Orndoff (1975); Piasecki (1975); Rutman (1976); Segal (1975); State of Michigan (1974); State of New York (1976).

cilities in certain neighborhoods, to a point of possible community saturation" (Wolpert 1975*b*). Some effects of this problem are the diminishing of real estate values and out-migration of the resident population. There are other kinds of problems in rural areas. Population sparsity creates problems in absorption of deviants. A special problem of increasing numerical significance in rural areas, not as yet reported in the published literature, is explained by R.D. Morrison (1976), who refers to the "tragic recruitment into the migrant labor stream of prematurely or inappropriately discharged mental patients who relapse under the strain of migrant existence and become expensive charges" of the Commonwealth of Virginia.

C. *Ecological impacts on economy of hospital community and on hospital staff*—The economic structure of communities in which large mental hospitals are located may be entirely dependent on the existence of the hospital. Dingman (1974) asserts that "dozens of towns in the United States owe their existence entirely or principally to a state hospital. In many dozens more localities, the state hospital has provided the largest single source of demand for the development of supply systems, educational systems, and so on. The ecological impact of a state hospital closing is unassessable—staggering—incredible in its proportions. The fact that we have no notion as to how to meet our obligations to these communities does not make the obligation go away." In addition, there is evidence that the closing of mental hosptials has adverse effects on the morale of staff (Greenblatt 1974; Ishiyama 1974; Khan and Kaplan 1974; Schultz, Lyons, and Nothnagel 1975; Weiner, Bird, and Associates 1973; Whittington 1969) who are concerned with their chances for alternative employment (American Federation of State, County and Municipal Employees 1973; Anonymous 1975*e*; Anonymous 1976*e*; California State Employees' Association 1972; Feldman 1974; Horizon House Institute 1975*b*; Weiner, Bird, and Associates 1973). The morale factor, in turn, may affect the quality of patient care provided during the period when the hospital is preparing to close.

D. *Effects on patient's family*—"Returning patients to their families," says Doll (1976) "is, of course, a logical step in the deinstitutionalization movement. And yet as progressive as that movement is, it may be causing serious crises in the lives of those families who are now responsible for the care and rehabilitation of relatives released from mental hospitals." Arthur (1973) claims that the "question of whether there are long-term subtle deleterious effects on other family members has yet to be resolved." A report by Doll (1976) indicates that even in the short-run, the patient's presence at home may put severe emotional and social strain on other family members, and he argues that if "family crises [are] severe enough, the trend toward community care may have to be reversed and permanently replaced by institutional care." Slovenko and Luby (1974) assert simply that "it is not to be forgotten that the family too is to have rights." [12]

V. Financial and fiscal issues:

Numerous references deal with the financial and fiscal problems associated with community care.[13] Opinion concerning the cost-benefits of community over hospital-based care is divided, but there seems to be consensus that the deinstitutionalization movement is encountering substantial fiscal problems. In fact, according to Kirk and Therrien (1975), the knowledge required to make accurate cost assessments is simply not available. They refer to "the transfer of major fiscal responsibility . . . from the mental health facilities to the public welfare enterprise," and conclude that "no one knows the magnitude of these hidden costs of community mental health or how they compare with the costs of hospitalization." Among such hidden costs are the "indirect costs incurred by other community agencies that are called upon to deal with the patients"—e.g., police, courts, emergency rooms, family agencies, etc. (Kirk and Therrien 1975). Arnhoff (1975) suggests that, after considering these intervening variables, the "actual cost-benefits of community treatment . . . are far less than its advocates proclaim."

VI. Legal and quasi-legal issues:

Ennis (1975, p. 83) writes (reprinted by permission of the publisher, Lexington Books, D. C. Heath and Co.):

> Courts have always been concerned to some extent with the legal rights of persons facing in-

[12] Other references dealing with the effects of deinstitutionalization on patients' families include: Arnhoff (1975); Creer and Wing (1974); Cumming (1975); Doll, Thompson, and Lefton (1976); Falk and Murphy (1976); Heinemann, Yudin, and Perlmutter (1975); Hill House (1975); Robbins and Robbins (1974); Strauss (1975).

[13] See, for example: Macht (1974); McClintock (1975); Murphy and Datel (1976); Peterson (1976); Sharfstein and Nafziger (1976); Sheehan and Atkinson (1974).

voluntary commitment to a state institution for the mentally ill or mentally retarded. But until very recently courts have refused to look behind institution doors. It is, literally, only in the past five years that courts have begun to consider the rights that patients retain inside such institutions once they are there lawfully. The rights that have become the focus of that examination include the following: the right to treatment; the right to refuse treatment; the right to protection from harm; the right to be paid for institution-maintaining labor; the right to be treated in the least restrictive setting and in the least restrictive and intrusive manner; the right to a free lawyer to resolve problems resulting from and problems separate from institutionalization; the right to a nonrenewable limitation on the permissible period of involuntary institutionalization; the right to decent living conditions—including the right to regular outdoor exercise, adequate clothing, and adequate medical care; the right to a public education regardless of the degree of mental handicap; and the right to meaningful notice—not just notice, of these and other rights.

With the deinstitutionalization movement, concern about these rights has followed patients as they have re-entered and/or taken up residence in the community. Legal and quasi-legal issues in deinstitutionalization are extremely complex and have increasingly been the subject of a number of excellent and informative treatises.[14] In addition, such issues increasingly are becoming the subject of concern in lay publications.[15] One major focus in this area, which has lately become the target of vigorous debate, is the matter of "dangerousness." Zitrin (1976) reports that records of discharged patients from the Bellevue Hospital catchment area show criminal arrest rates, including rates for violent offenses, that are higher than corresponding rates in the community. Langsley, Barter and Yarvis (1976) assert that "mental health professionals are not good predictors of dangerousness"; Dix (1976) concurs in this view. Perhaps in this particular problem lies a substantial portion of the explanation for the emotionalism and polarization surrounding the entire question of deinstitutionalization.

VII. Informational issues and accountability:

A. *Necessity for evaluation studies*—Effective and conclusive research has lagged in the deinstitutionalization movement. Even the extent to which community-based facilities and mental hospitals tend to serve the same—or different—patient populations is not yet known: Reports on this matter show conflicting results.[16] In order for realistic and effective program planning to take place, it is first essential to identify the population which is to be served and then to ascertain whether the target group(s) are being reached (Bachrach 1975*a*). It is also necessary to have ongoing evaluation studies to provide the feedback necessary for planning and implementing modifications in programs already in process (Glenn 1975; Goertzel 1976; Hargrove 1970; Matlins 1975; Schapire 1974; State of New York 1976; Yudin and Ring 1971; Zusman 1971; Zusman and Ross 1969).

B. *Difficulties in locating and following patients in the community*—Many of the followup studies already conducted have shown substantial percentages of released patients who could not be located in the community.[17] Thus, many followup studies are based on samples which are biased by the exclusion of patients who could not be contacted.[18] The inability to locate individuals for followup studies is, of course, a reflection of the inability to locate them for purposes of pursuing prescribed treatment courses.

C. *Inadequacy of existing followup studies*—The question of what actually happens to patients who leave mental hospitals and re-enter the community is largely unanswered. Although many followup studies with varying degrees of sophistication in

[14] Selected references include: Anonymous (1976*c*); Bazelon (1976); Dix (1976); Ennis (1975); Flaschner (1975); Langsley and Barter (1975); Langsley, Barter and Yarvis (1976); McDonald (1974*a*); McGarry (1976); Monahan and Geis (1976); Redlich and Mollica (1976); Robitscher and Luce (1976); Schdev (1976); Slovenko and Luby (1974); Stone (1974); Stone (1975*a*); Stone (1975*b*); Zitrin et al. (1976).

[15] See, for example: Anonymous (1976*a*); Kiernan (1976); Knight (1976); Smith (1975).

[16] See, for example: Aanes, Klaessy, and Wills (1975); Arthur Bolton Associates (1975); Bockoven and Solomon (1975); Dyck (1974); Kentsmith, Menninger and Coyne (1975).

[17] See, for example: Anonymous (1975*a*); Bristow, Harris and Henderson (1966); Horizon House Institute (1975*a*); Place and Weiner (1974); Wiggins (1970).

[18] Numerous references deal with the difficulties of tracking mental patients in the community. Selected examples include: Bachrach (1972*b*); Bachrach (1972*c*); Bachrach (1976*b*); Feldman (1974); Kedward et al. (1974); Kramer (1970).

design are reported in the literature,[19] their results are largely inconclusive in any broad sense. For the most part, these works have very limited replicability and generalizability (Bachrach 1976*a*). There is a need for more followup studies of mental patients after their release into the community (Kedward et al. 1974; Rosenblatt and Mayer 1974); and these studies should have comparability and generalizability in order that meaningful decisions regarding community-based care can be made. In short, "we need accurate, standardized information regarding our present systems of care in order to make just and rational decisions regarding future allocations of scarce mental health resources" (Greenblatt and Glazier 1975).

VIII. Additional issues resulting from the process of deinstitutionalization itself:

A. *Timing: precipitate implementation of new programs*—Deinstitutionalization has often proceeded with such rapidity that there has hardly been time to plan carefully for community-based programs with a view toward meeting special needs and overcoming special problems of target groups. Issues of acceptability and inaccessibility of services have often been overlooked in the haste of implementing new programs.[20]

B. *Inadequate attention to patients' desires*—A thought-provoking article by Mayer and Rosenblatt (1974) points out that "the opinions of mental patients traditionally have been ignored by mental health researchers, although they are most relevant if patient care is to be improved. A comparison of patient and staff opinion reveals that patients have a more positive view of the hospital, and disagree with staff in their conceptions of what makes patients 'get better'." Herjanic, Stewart and Hales (1968) caution that a successful community program must "be satisfactory to the patient." Although some investigators[21] approach or attest to the importance of this area of concern, the problem is distinguished more by oversight than by prominence in the literature.

C. *Problems related to providing adequate services in hospitals during phase-out*—This issue is summarized in a statement by Kram (1975): "It is unrealistic to expect a hospital to function at its best in the midst of funding cutbacks or after a decision has been made to close it." Staff morale and uncertainty about the future become matters of concern in this connection.

D. *Failure to establish liaison between hospitals and community-based facilities*—Inextricably tied up with the problem of inadequacy of followup procedures is a situation wherein deinstitutionalized individuals must sometimes fight their way through massive red tape in order to be treated in the community. A former patient makes this observation: "Sometimes it seems as if the mental health care system has become so complex that one needs a college degree just to be a patient" (Hoshall and Friedman 1975). This problem is closely related to the fragmentation of community services and to the failure to provide adequate community support systems as described above.

E. *Role-blurring*—Mental hospitals have a notable advantage over more loosely structured community-based facilities in that, at the former, the social structure is more clearly defined. There is an easier understanding of statuses and roles—of who does what for or to whom and in what contexts. Some may object to the actual normative content of the statuses in hospitals, but at least the definitions are there and are relatively clear. When patient care is transferred out to the community, traditional definitions no longer seem to work, and *anomie*—a "social condition characterized by a general breakdown, or absence of norms governing group and individual behavior" (Hoult 1969, p. 21)—results. Thus, Sanders (1974), who writes that "it is quite obvious that the chronic mental patient does establish and generally maintains a stabilizing role in the hospital, which is something he has not been able to accomplish in the community, even on a minimal level," connects such role-blurring with high recidivism. Not only does role-blurring occur among patients, but it also occurs among staff members in the community. Ochberg (1976) attributes this situation to the existence in the community of "curious and creative people discovering ways to use their skills in new settings" and anticipates that the confusion

[19] See, for example: Anthony et al. (1972); Davis, Dinitz, and Pasamanick (1972); Davis, Dinitz, and Pasamanick (1974); DiScipio (1973); Fakhruddin, Manjooran, and Nair (1972); Franklin, Kittredge, and Thrasher (1975); Grenny and Crandell (1973); Herjanic, Stewart, and Hales (1968); Lafave, Stewart, and Grunberg (1968); Lamb and Goertzel (1972*b*); Martin and Sterne (1975); McClintock (1975); Michaux et al. (1969); Myers and Bean (1968); Place and Weiner (1974); Singer and Grob (1975); Wiggins (1970).

[20] Selected references dealing with the problem of timing include: Becker and Schulberg (1976); Easton (1974); Glenn (1975); Jones (1975); Robbins and Robbins (1974).

[21] See, for example: Mechanic (1968, p. 89); Sanders (1972); Wanberg, Horn, and Fairchild (1974).

-ventually "unravel." Pattison et al. (1976) . that the Orange County (California) Dement of Mental Health has found it expedient levelop a code of ethics for employees as the lt of "problems of role definition and interiplinary collaboration" in the development of mmunity program. Additional references amplig problems of role-blurring include Glass 75) and Miller (1974).

. *Disenchantment with the deinstitutionaliza- movement: resistance to further change*—As ed by Becker and Schulberg (1976):

> The vast majority of patients currently cared for n state hospitals could be adequately treated in the community if a comprehensive spectrum of psychiatric services and residential alternatives were established. The failure to establish this network of community services before the discharge of thousands of patients has discredited the deinstitutionalization programs in many states.

his issue is closely related to the issue of timing scussed above (Easton 1974). In addition, some riters feel that the deinstitutionalization movent has been remiss in failing to define its boundries clearly. In seeking to assist in a variety of ocial, as well as psychiatric, problems—in attempt- to fill the lacunae perceived in mental hospital tment—the movement has sought, according to Lasch (1976) to "provide a universal cure for the niseries of existence." This has at times proved to e problematical, though not altogether without positive value in program implementation.[22]

Synthesis

Each of the issues examined here may be viewed as an intervening variable in the success of the deinstitutionalization movement. The aggregate effect of these complex and interrelated issues has been to create a situation wherein the movement has, since its inception, confronted obstacles every step of the way. It is almost as if it has been on a collision course, encountering roadblocks at every turn and creating new barriers in the process of trying to remove old ones.

One of the ironies that strikes the student of deinstitutionalization is that the issues discussed here are not necessarily newly revealed. One can only speculate as to whether the problems which the movement faces today are inevitable consequences of social change, or whether some of these problems might have been avoided or mitigated had more notice been taken when they were first mentioned in the literature. Kramer et al. (1956), for example, wrote as long as 20 years ago:

> So that we may really be able to assess what a course of hospitalization has accomplished, we need answers to questions such as the following: of patients who have been returned to the community, how many relapse and how soon? How are relapse rates related to diagnosis, sex, age on admission, length of hospitalization, therapy? What social and environmental factors encountered by discharged patients are related to relapse or successful readjustment? Accurate follow-up data on discharged mental patients can serve as the basis for "discharge prediction" techniques, weighting significant factors in the patient's life history, diagnosis, clinical course in hospital, degree of improvement, and expected family and community environment. Better understanding of relapse factors would greatly aid the development of rehabilitation programs for patients while they are still in the hospital and later when they have returned to the community.

Thus, it is not as if some of the questions that needed to be asked before the deinstitutionalization movement took on momentum were never raised. They were raised; but, in practice, they were not acknowledged. The movement went forward on its own momentum, too often impervious to attempts to steer it onto a course consistent with clinically derived principles and theoretically derived expectations.

[22] See, for example: Cumming (1974); Dinitz and Beran (1971); Rosenfeld (1976); Wagenfeld (1972).

IV. A FUNCTIONALIST PERSPECTIVE

"Because of the interdependence of the components of society, change at any one point is likely to precipitate changes elsewhere. These changes may come unheralded, unpredicted, and frequently from the viewpoint of many groups, unwanted."

—Ely Chinoy, 1954

The functionalist approach in the behavioral sciences consists of a series of basic concepts which are interrelated within a theoretical framework fundamentally oriented toward the understanding of social change. In the present section of this study, some of these concepts will be explained and will then be applied to the issues described in the previous section. The importance of social change within the functionalist framework will then be emphasized as the basis for further examination of deinstitutionalization issues.

BASIC CONCEPTS IN THE FUNCTIONALIST APPROACH

The central concept in functional analysis is the *function,* which is defined in terms of contributions to the "fulfillment of one or more social needs of a social system or subsystem" (Johnson 1960, p. 63). In brief, each form or element of a social system—whether a cultural item, pattern, status, norm or value—is identifiable in terms of the functions it serves for society, or, in other words, in terms of the social needs which it fulfills. Note that a *function* is to be differentiated from a *purpose,* and that this distinction is an important one. Although the two may be, and often in particular instances are, identical, a purpose is to be regarded as something subjective, a charge; a function is to be regarded, by contrast, as an objective phenomenon. In very simplified terms, a purpose is that which a social form is intended to do, and a function is that which a social form actually does. To illustrate, the purpose of opening a crisis center may be to provide ready intervention in emergency situations; the functions of the crisis center may include, in addition to this purpose, other functions, such as providing employment for telephone operators and providing outlets for community service organizations. In fact, these latter functions may persist in keeping the crisis center open even if the original purpose of emergency intervention is no longer being fulfilled.

Functions are to be understood as positive phenomena, in that they fulfill societal goals or objectives and thus contribute to the survival of society's institutions. Sometimes, social forms are, however, negative in consequence and actually inhibit the realization of societal goals. In such cases, the social forms are said to be dysfunctional. The distinction between function and dysfunction is described in this way by Merton (1957, p. 51): "*Functions* are those observed consequences which make for the adaptation or adjustment of a given system; and *dysfunctions,* those observed consequences which lessen the adaptation or adjustment of the system." Thus, for example, operators' personal use of crisis center telephone lines to the extent of interference with the receipt of emergency calls becomes a dysfunctional element in the enterprise. A given social form may be both functional and dysfunctional, depending on the point of view of particular social subsystems. In our simplified example, the telephone operators may realize fulfillment of personal goals, while the organizational goals of the center are being inhibited by the influx of non-business calls.

Functions may also be characterized according to whether they are manifest or latent. *Manifest functions* are, in general, those that are "intended and recognized by the participants in the system" (Merton 1957, p. 51). Contrariwise, *latent functions* are unintended, and, for purposes of the present study,

may be understood as *unanticipated consequences* given social forms. Latent functions are not necessarily dysfunctional, although they may be. The illustration of the inaccessible telephone lines is clearly both unanticipated and dysfunctional. On the other hand, the provision of employment opportunities for telephone operators, while a latent function, is positive and hence not dysfunctional. The importance of the distinction between manifest and latent functions is explained by Chinoy (1954, pp. 39–40):

> It is essential in examining the functions of social institutions to distinguish between the purposes or reasons which are conventionally given for their existence and the objective consequences which flow from them. Purpose and result need not and in most cases probably do not completely coincide. . . A distinction therefore must be made between manifest and latent functions.

An additional concept in the functionalist approach is that of the *functional alternative*. This is explained by Merton (1957, pp. 33–34):

> . . . *just as the same item may have multiple functions, so may the same function be diversely fulfilled by alternative items.* Functional needs are here taken to be permissive, rather than determinant, of specific social structures. Or, in other words, there is a range of variation in the structures which fulfill the functions in question.

It now becomes increasingly clear, in the context of the functionalist perspective, that *the deinstitutionalization movement in the United States represents a search for functional alternatives to the mental hospital.*

APPLICATION OF CONCEPTS: THE FUNCTIONS OF ASYLUM AND CUSTODY

This characterization of the deinstitutionalization movement as a quest for functional alternatives demands that the functions—manifest and latent—of the mental hospital be made explicit. An attempt to do so, at least partially, was made in a largely overlooked article by a psychiatrist, Robert M. Edwalds, over a decade ago (1964). Edwalds held that "the primary social functions of the state mental hospital are not the same as the publicly proclaimed purposes and goals of these institutions." He wrote:

> Primary functions demanded of the state mental hospital have included (A) public safety and the removal from society of individuals exhibiting certain kinds of socially disruptive behavior; (B) custodial care for persons who, by reason of mental disorder, cannot care for themselves or be cared for elsewhere. . . Treatment and rehabilitation of the mentally ill has always been, at best, a secondary function of the state mental hospital. For many years it was not considered part of the function of the state hospital at all. Today treatment and rehabilitation are usually officially regarded as the primary functions of the state mental hospital, leading to a remarkable amount of self-deception and confusion on the part of society and the personnel working in these hospitals.

Edwalds saw the very use of the term hospital to refer to these mental institutions as misleading and productive of naive misunderstanding of the "true" functions.

What Edwalds was saying, translated into functionalist terms, is that, although the stated goal of the mental hospital may be treatment and rehabilitation of the mentally ill, this is at best only a limited function. Instead, the major functions of the mental hospital are, in reality, custodial in nature. These custodial functions of mental institutions are grounded in the social history of this Nation (Dain 1971; Jarcho 1976; Rutman 1976).

The importance of Edwalds' position cannot be overemphasized! If his characterization is accurate, a giant step toward understanding the issues inherent in deinstitutionalization was taken over 10 years ago, when the movement was young. To the extent that Edwalds' theory has validity, it may be hypothesized that *many of the problems confronting the deinstitutionalization movement result from the failure to provide functional alternatives for some of the basic functions served by the mental hospital.* The logical conclusion that follows from a functionalist point of view is that *mental hospitals must not and cannot be eliminated until alternatives for the functions of asylum and custodial care have been provided.*

The early literature on deinstitutionalization, which reflects the mood underlying program planning in the 1960's, largely ignored or discounted these custodial functions of mental hospitals. Instead, the focus was on providing *treatment* (not custodial care or asylum) in the community. But, as it turns out, Edwalds was prophetic. His name is, for the most part, absent from bibliographies and literature reviews.[23] Yet, recognition of the

[23] A notable exception is Dingman (1974), who utilizes the Edwalds article as the basis for much of a cogent argument favoring the retention and meaningful modification of the State hospital.

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functions of asylum and custody has become more and more prevalent in the literature of the mid-1970's. Thus, Slovenko and Luby (1974) write:

> The medical model terminology has been misleading. When we use the term "hospital," we naturally think of treatment. Hospitalization without treatment is an absurdity. . . If, however, we understand by the term "hospitalization" nothing more nor less than asylum (as the mental hospital at one time was called), a place of refuge, there is no connotation of medical treatment but rather one of treatment in the broad sense as meaning "handling of" or "how we treat one another."[24]

Fowlkes' article, entitled "Business as Usual—at the State Mental Hospital," (1975)—one of four recent articles cited earlier as contributing substantially to elucidating the issues in deinstitutionalization—is entirely devoted to an examination of those forces which serve to resist innovations at State mental hospitals and thus to preserve them as custodial institutions. Fowlkes, in effect, perceives a kind of conflict of interest in which institutionalized (in the sociological sense) aspects of the mental hospital are functional for some societal groups (hospital administrators and staff, patients' families, vested economic interests, etc.), but dysfunctional for others (patients).

If corroboration from modern experts is to be regarded as a measure of the validity of Edwalds' theory, one can only conclude that he was indeed on the right track at the wrong time.

APPLICATION OF CONCEPTS: ADDITIONAL FUNCTIONS

An attempt to isolate some of the functions of mental hospitals as identified in the literature yields the following listing:

- Providing long-term care for chronically disturbed individuals (Dingman 1974; Stewart 1975)
- Providing respite from mounting pressures for the patient (Dingman 1974; Stewart 1975)
- Removing the patient from "his usual interpersonal environment which may operate to perpetuate sick behavior" (Lewis 1973)
- Protecting the patient from "undue pressure" or exploitation by others (Dingman 1974)
- Providing a residential environment for the mentally ill (Fowlkes 1975)
- Providing constant and continuous monitoring and review of the patient's course of illness (Lewis 1973)
- Providing a social structure within which the role of the mentally ill individual is clearly defined (Rosenhan 1973; Sanders 1974)
- Providing the mentally ill individual with an alternative to due process of law (Polak and Jones 1973)
- Providing a place for escape for the patient from the society in which his behavior is "friction producing" (Polak and Jones 1973)
- Providing the means by which society can segregate its deviants (Polak and Jones 1973)
- Relieving the patient's family and community from disruptive social interaction (Fowlkes 1975; Aviram and Segal 1973; Doll 1976; Doll, Thompson, and Lefton 1976); "absorbing the strains of sickness" (Susser 1964)
- Protecting society from the acts of dangerous individuals (Dingman 1974; Hanson and Babigian 1974)
- Supplying the least expensive patient care for the mentally ill "on a short-run, annual budget basis" (Fowlkes 1975)
- Providing the economic base of and employment for a community or a portion of a community (Fowlkes 1975; Dingman 1974; Weiner and Bird 1973; Keenan 1974; Schulberg, Becker, and McGrath 1976)
- Providing job security and other job perquisites for numbers of employed persons (Fowlkes 1975; Ishiyama 1974; Weiner and Bird 1973; Schultz, Lyons, and Nothnagel 1975; Dingman 1974; Keenan 1974)
- Providing a tax base for local communities (Schapire 1974)
- Providing for mental health professionals in the community a "siphon[ing] off [of] the least affluent and least attractive of the mentally disturbed, whom they would prefer not to serve anyway" (Fowlkes 1975)
- Creating an "illusion that all local mental health needs are being met, thus eliminating

[24] Selected additional references expressing the need to recognize the functions of asylum and custody at mental hospitals include: Bewley et al. (1975); Clausen and Huffine (1975); Chu and Trotter (1974); Cumming (1974); Dingman (1974); Finzen (1974); Lieberman and Gardner (1976); Rosenblatt (1974); Rosenblatt (1975); Rutman (1976); Saper (1975); Stone (1975*a*); Stotsky (1968).

the need for... local planning and spending for mental health care" (Fowlkes 1975)

- Providing a place for research on mental illness and training of mental health professionals (Dingman 1974; Stewart 1975)

This listing is limited to those functions of mental hospitals explicitly stated as such in the literature. Were it to be expanded by the inclusion of such functions as are also implicit in the literature, it would be even longer. But, even as it stands, it is sufficient to support an important observation. The issues in deinstitutionalization raised in the last section of this study fall into two major groupings vis-à-vis mental hospital functions. Either: (1) the issue has at least one referent among the functions listed, or (2) the issue has come into being as an unanticipated consequence—i.e., a latent function—of the deinstitutionalization movement. With respect to the former grouping, it is apparent that efforts to reduce the stature of, or eliminate, mental hospitals have too often failed to stress the necessity for alternatives to the custodial and other functions of mental hospitals. It is inevitable that any movement which so ignores the institutional makeup of society will encounter severe opposition.

With respect to the latter grouping of issues—those which emerge as products of the movement itself—it is apparent that the deinstitutionalization effort in process has not been viewed by its champions with sufficient detachment to permit program planners to recognize problems and introduce necessary modifications. Deinstitutionalization has left in its wake dysfunctional elements which result directly from rapid, and sometimes heedless, implementation of the movement.

In short, the ideological basis for deinstitutionalization is one which encourages rapid social change in an institution (in the sociological sense) which is woven into the fabric of American life. The semanticist, Hayakawa (1949, p. 276), explains the conservatism which such a threat engenders in his statement that "social institutions tend to change slowly—and, most importantly—they tend to continue to exist long after the necessity for their continued existence has disappeared, and sometimes even when their continued existence becomes a nuisance and a danger."

Part of the reaction against deinstitutionalization has resulted from society's resistance to what Coser (1975) calls the "threat of territorial invasion." Coser's argument (which deals with social change in other areas of American life) holds that geographical displacement typically constitutes enough of a threat to the existing social order to mobilize conservative antichange forces. Unless geographical displacement is "patterned in such a way that it will not interfere with the existing pattern of role relationships," it can become an intolerable threat to society. The role-blurring issue in deinstitutionalization provides evidence that geographical displacement in this instance has in fact interfered with role relationships and that part of the resistance to the movement may be understood in this way.

To recapitulate, the absence of acceptable functional alternatives for the functions served by mental hospitals, coupled with attempts to displace the territorial and other claims of the institutionalized system of mental health care—all occurring with great speed—have produced serious problems in implementing the goals of the deinstitutionalization movement.

A final word remains to be said regarding the functionalist approach. If there are gaps in the interpretation of deinstitutionalization that it affords, that is no surprise. It is not the intent of this study to suggest that the functionalist approach is *the* legitimate avenue to understanding deinstitutionalization. It is simply *an* approach, one which permits systematic ordering of the data, impressions, and judgments about deinstitutionalization that are found in the literature. Other theoretical frameworks will also be useful to this end, to the extent that they help to make sense of the elements in the process of deinstitutionalization and to unify seemingly discrete bits of material. In fact, other approaches should be viewed as potentially complementary to the functionalist perspective—as helping to enhance the understanding of elements that still appear to be at loose ends.

V. DISCUSSION

"Nowhere is the discrepancy between public and private morality, between verbal pronouncements and actual behavior, more apparent than in the field of psychiatric aftercare. The literature is replete with descriptions of demonstration projects, state-wide programs, bold innovations, and triumphs of interagency collaboration. Yet, an objective observer can quickly conclude, if he reviews the typical post-hospital experience of psychiatric patients, that aftercare services in reality do not exist for the vast majority of persons leaving state and local mental hospitals."

—H. G. Whittington, 1969

Has deinstitutionalization really, thus far, resulted in the exchange of one set of ills for another? Have the dysfunctional elements of institutional care merely been transferred to the community, so that, in the words of Slovenko and Luby (1975), "mental patients are going from the frying pan into the fire" and that "neglect in the community dwarfs neglect in hospitals"? If one proceeds from the assumption that the basic goal of the deinstitutionalization movement is the elimination of dehumanization in the treatment of the mentally ill,[25] one must acknowledge that, on the basis of the existing literature, community-based programs have not been immune to dehumanizing forces.[26] While the position taken by Slovenko and Luby may be an exaggerated or polarized statement, it does now seem clear that the deinstitutionalization movement has not had unqualified success in its humanizing mission. Like other movements of social reform, it has produced a series of largely unanticipated consequences (latent functions) of a dysfunctional nature; like other efforts at institutional change, it has brought into play the forces of resistance which have themslves at times been dysfunctional.

But this by no means necessarily indicates that the movement is a failure. It does, instead, mean that the time has come to face the issues squarely, so that the movement can achieve its promise. For example, it may now be understood—and potentially acted upon—that the issue of selecting patients for community care is closely related to the functional confusion described by Edwalds. Selection of a patient population or target group follows from an agency's understanding of its *raison d'être*. But if it is unclear what functions are to be transferred from the mental hospital to the community, it must also be unclear which patients should be served in the process. The deinstitutionalization movement may eschew the functions of

[25] Orndoff (1975, p. 222) adopts this assumption emphatically: "Institutionalization is a dehumanizing process where the patient's individuality is lost, his self-concept greatly lowered, and in many cases, his ability to make even the simplest life decisions seriously impaired. With this in mind, the goal of any community residential program must be to reverse the process."

[26] Perhaps an exercise utilizing the concepts of the sociologist Jan Howard (1975, pp. 60-66) can assist the reader in assessing the presence of dehumanization either in general or in specific instances where deinstitutionalization programs have been implemented. Howard isolates and describes 11 different referents of the concept dehumanization. The referent characterized as "thinging," the reduction of human beings to things, must certainly be viewed as part of the horror-story quality of life in many mental hospitals, as must another referent, "dehumanization by degradation." In general, deinstitutionalization efforts have succeeded only in partially eliminating these dimensions of dehumanization. On the other hand, in some instances where the rapid disgorgement of patients into communities without adequate provision for alternate care has taken place, other dimensions of dehumanization have been brought into play—for example, the experiencing of isolation and abandonment, and the production of groups of patients without options.

custody and asylum; but it must still acknowledge that these have been functions of the mental hospital, the need for which will not simply disappear with the dismantling of custodial facilities. With this recognition can come modified planning and action.

A major shortcoming of the deinstitutionalization movement, one which has clouded the issues and confounded investigative efforts, has been the tendency of persons connected with selected community programs to reason inductively that the entire movement is "working," when obviously this is not always the case, thus deflecting attention from the issues which must be resolved. A number of experimental community treatment models which report success are described in the literature,[27] and some of these are exceedingly innovative. However, persons encouraging the diffusion of specific treatment models frequently fail to comprehend the dimensions of the deinstitutionalization problem and the fact that their programs care for only a small portion of deinstitutionalized individuals. They frequently, in addition, fail to take into account that: (1) the resources—both personnel and financial—of their own communities may not be available to other communities; and (2) their specific programs may not be compatible with the culture bases in other communities. Too often, these programs preselect patients to fit in with criteria set by experimental design, and their supporters sometimes forget that these selected patients are not representative of *all* mentally ill people.

There have certainly been commendable community programs, and the importance of these is not to be minimized either in humane or experimental terms. But, at the present time, such isolated programs can only be perceived as bandaids. We must not delude ourselves into thinking that any one or a combination of such programs provides comprehensive answers to the massive problems of the deinstitutionalization movement. Although proponents of specific localized problems may be certain that one or another selected approach is "the answer," on a more general level it may well be asked, "What is the question?" In functionalist terms the question becomes one of identifying the appropriate functions of mental hospitals and the providing of functional alternatives in the community on a widespread—not just local—basis.

[27] Selected examples from among numerous reports include: Birley (1974); Brook et al. (1976); Claghorn and Kinross-Wright (1971); Driemen and Minard (1971); Elpers (1975); Guillozet (1975); Hofstatter et al. (1972); Kresky, Maeda, and Rothwell (1976); Lafave, Stewart and Grunberg (1968); Langsley, Barter and Yarvis (1976); Lanter (1976); Lowinson and Langrod (1975); Marx, Test, and Stein (1973); Mosher, Menn, and Matthews (1975); Polak and Kirby (1976); St. Clair (1975); Sanders (1972); Smith (1974); Stein, Test and Marx (1975); Test and Stein (1976); and Walter (1976).

VI. CONCLUSIONS

"That reform movements often create more problems than they solve has been noted, and the task of each succeeding generation is to correct the excesses of the last. . . There comes a time when reformist zeal must be matched against available data, and while the humanistic goals may persist the paths to them must be modified. This clearly is overdue for the field of mental health."

—Franklyn N. Arnhoff, 1975

"Fundamentally, the need that must be faced is the establishment of programs to meet the needs of people whether they are in institutions or in the community."

—Ralph Slovenko and Elliot D. Luby, 1975

The basic conclusions of this study are simple, and, it seems, inescapable. 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: (1) there is a thorough understanding of the functions which they serve in American life; (2) consensus is reached as to which of these functions should be continued or discontinued, or which new functions should be added; (3) effective alternatives are established in community settings for the accepted functions; and (4) sufficient time is allowed for the systematic and orderly implementation of new programs and transfer of functions.

In one important respect the deinstitutionalization movement has come a long way. The era of polarization seems to be passing, and, finally, the voices of moderation are being heard. This sets the stage for more realistic planning. However, there still remain some very serious problems with which to contend. Although it is increasingly recognized that there must be a range of treatment alternatives including a variety of hospital- and community-based choices, there is little in the way of consensus regarding what *kinds* of service facilities can best fulfill what *kinds* of functions. Some choices must be made. Mental health service delivery agencies, particularly those which might appear to be less traditional and more innovative, have what Franklin and Kittredge (1975) call serious problems of legitimacy and boundaries. Legitimacy involves the "defining of a domain, a set of tasks or activities over which the organization claims jurisdiction." Whereas organizations whose services can easily be measured by accepted objective criteria have relatively less difficulty in establishing boundaries, it is extremely difficult to define boundaries for what these writers call "people-changing organizations." One reason is that there is considerable overlap in the jurisdictional claims among such agencies. The "boundary busting" nature of community mental health—its tendency to blur the boundaries of other agencies—is the subject of timely and thought-provoking discussions by Dinitz and Beran (1971) and Wagenfeld (1972).

If the deinstitutionalization movement is to proceed more effectively, it would seem that a first step to take is to define precisely, in the light of accumulated experience, what are the target groups for the movement. Precisely which patients are to be deinstitutionalized? What patients do we mean when we talk about providing community care? Do we mean all persons in mental hospitals, or do we mean only those, who by virtue of specific demographic or diagnostic characteristics they possess, may be assigned to some localized experimental

program? Do we mean patients who are hospitalized primarily for lack of other places to go—i.e., inappropriate hospitalizations?[28] Or do we mean only those patients who might be considered "good risks" for rehabilitation via the community route?

Lest this study appear to place undue emphasis on the negative aspects of deinstitutionalization, let it be made clear that the aim of this work is supportive in nature. In fact, this study may be regarded as an endorsement of the major goal of deinstitutionalization. Were this not the case, there would be no need for such a study. Focusing on dysfunctional elements of the movement is not an indictment but rather a necessary step in bringing to the surface those factors which have inhibited the movement's success. The final conclusion, of course, is that the deinstitutionalization movement can best proceed on its humanizing mission if it avoids territorial arguments: it is not necessary, and probably not desirable at this time, to expunge the mental hospital in order to achieve the goal of deinstitutionalization. It is certainly unwise to attempt to do so in haste. Community planners need to understand that hospitalization "does not, as some have suggested, signify the failure of alternative methods of care" (Adams 1975). There is a need to re-assess the functions which are known to be served by mental hospitals and to determine, without prejudice, those which are not likely to be fulfilled in community settings.

Mental hospitals that survive the deinstitutionalization movement can themselves aid in the humanizing effort. These hospitals will have the potential for elevating patient treatment to a primary function; the functions of asylum and custody do not preclude this. In addition to the brief hospitalization trend cited earlier, which can be implemented in mental hospital settings, other innovative programs can be encouraged. Day care, or partial care, which "apparently avoids the regressive features associated with 'total institutionalization'" (Herz et al. 1971)[29] is one such kind of program. Hospital-based outpatient care and outreach programs are others (Stubblefield 1976a; Texas DMHMR 1976). The siting of such programs at mental hospitals can in fact aid in overcoming the issue of fragmented care, especially if transportation for patients is facilitated. Along these lines, Johnson et al. (1975) advocate the "mini-mental health center," a program which provides both inpatient and outpatient care on a single hospital ward, thus allowing for comprehensive treatment by the same treatment team. These authors point out that the traditional mental health center can provide *continual care*, but their program has a capability for real *continuity of care*, which is not the same thing.[30]

Still other steps can be taken to make the movement more responsive to the needs of patients. Certainly one area where change is essential is in the setting and monitoring of standards for residential facilities. It is important to remember, in the words of Crane (1974), that "hospital substitutes, like halfway houses, day care centers, and nursing homes, can cope with a limited number of patients. The quality of their services can only deteriorate when the demand becomes excessive." Care must be taken to assure that such facilities are not overloaded or oversold.[31]

Another avenue for the enhancement of the goals of deinstitutionalization is the local screening of patients before their admission to mental hospitals. Screening programs can assist in the determination of which individuals definitely require custodial care and which can best be treated outside of institutions (Feldman 1974). Protests of partisans notwithstanding, screening can also assist in determining whether there exist patients for whom community-based care is *not* the treatment of choice and for whom hospitalization might really be the desired alternative. Finally, in addition to preadmission screening for assignment or nonassignment to mental hospitals, there should be screening for the variety of care-giving agencies within the community as well. The screening program should thus take reponsibility for assignment of patients to residential facilities as well as treatment services.

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[28] The literature contains a number of studies dealing with inappropriate placement of patients in mental hospitals. Selected references include: Arthur Bolton Associates (1974); Arthur Bolton Associates (1975); Lund (1976); Sheehan and Craft (1975); Fottrell and Majumder (1975); Washburn, Vannicelli and Scheff (1976).

[29] Also see: LaCommare (1975); Lamb (1976*b*); McNabola (1975); Michaux et al. (1973*a*).

[30] Also see: Fox and Potter (1973); Hott (1971).

[31] A variety of references deal with the place of halfway houses and other residential facilities in the deinstitutionalization movement. Selected references include: [illegible] (1976*f*); Atkinson (1975); Cannon (1975*a*); [illegible] Edelson (1976); Horizon House Institute [illegible]; [illegible] (1976*a*); Orndoff (1975); Ozarin and Witkin [illegible]

Just as pre-admission screening may serve to minimize dehumanization, so should an effort be made to enhance the role of pre-release planning at mental hospitals. Many patients must be trained for life on the outside, and this represents a major opportunity for innovativeness and originality in the hospital setting. Pre-release planning must include, at a minimum, an effective referral mechanism. Zolik, Lantz, and Sommers (1968) have shown that patients released without referral are more frequently and more readily rehospitalized than those who have been given referrals. Pre-release planning must also include plans for the followup of patients in the community. Such plans must be prospective and must precede the patient's release. It is simply too difficult to track a patient retrospectively. Liaison personnel, who work between hospital and community-based facilities, are essential for followup.

It is important that the territoriality exhibited by competing community-based treatment and service agencies be neutralized by cooperative effort. It is possible to develop community-wide mental health plans which endeavor to implement the aims of competing organizations and to express the consensus of all participating units (Bachrach 1974). Such cooperative planning is to be strongly encouraged: it provides specific agencies with the knowledge that their views count and their contributions are valued. J. Howard (1975) provides a theoretical framework which may be used to view the fragmentation of community services in mental health. She presents four models of interaction between professionals and patients. In the 1:1 model a single professional provider relates to a single consumer. The 1:*n* model typifies one provider relating to more than one consumer, the *n*:1 model depicts a relationship between more than one provider and one consumer, and the *n*:*n* model contains both multiple providers and multiple consumers. Fragmentation, which is absent from the 1:1 model, is most pronounced in the *n*:*n* model. Deinstitutionalization has frequently resulted in a variety of service relationships with multiple producers and/or consumers and especially those of the *n*:*n* type. While this is not an "inherently depersonalizing" service model, Howard does suggest that it may present the most obstacles to humanized care.

Finally, not enough can be said about the importance of improved information systems in implementing the goal of the deinstitutionalization movement. It is essential that we know who is being treated where, with what success, and for what reasons. Unless a mental health plan can check itself and modify itself in process, its efforts run a huge risk of veering off-course and producing dysfunctional patterns which become increasingly difficult to reverse. The only way to assure that specific programs connected with deinstitutionalization efforts do not autonomously take on questionable latent functions is by effective monitoring and continuing assessment of their relevance through process and outcome evaluation. We can only know whether community mental health care "works" if we have the data to substantiate our premises. A quotation by Matlins (1975) is apposite:

> The basic function of planning and the research activities that take place as part of the planning process is to improve the quality of decisions made over time. The most striking characteristic of many planning systems is their failure to impact on the decision making process. While planning in a vacuum often produces documents that are impressive from the point of view of technical craftsmanship, such planning rarely impacts on decisions. Planning's reason for existence is to improve the quality of decisions.

It would appear that major hurdles have been negotiated and that it is possible to be optimistic about the future of the deinstitutionalization movement. The movement has passed through an infancy, a childhood, and a rebellious adolescence. It is now ready to embark on a mature quest for answers to the issues which have plagued it.

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A Model for Deinstitutionalization

ABSTRACT. One of the most critical concepts affecting the lives and services for the retarded today involves deinstitutionalization. This paper explores some of the problems associated with this process and considers five aspects deemed important to a successful effort.

R. C. Scheerenberger

ON FEBRUARY 5, 1963, PRESIDENT JOHN F. KENNEDY concluded his message to the Congress of the United States with the following challenge:

> We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower.
>
> This tradition of neglect must be replaced by forceful and far-reaching programs carried out at all levels of government, by private individuals and by State and local agencies in every part of the Union.
>
> We must act—
>
> to bestow the full benefits of our society on those who suffer from mental disabilities;
> to prevent the occurrence of mental illness and mental retardation wherever and whenever possible;
> to provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders;
> to stimulate improvements in the level of care given the mentally disabled in our State and private institutions, and to reorient those programs to a community-centered approach;
> to reduce, over a number of years, and by hundreds of thousands, the persons confined to these institutions;
> to retain in and return to the community the mentally ill and mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services; and
> to reinforce the will and capacity of our communities to meet these problems, in order that the communities, in turn, can reinforce the will and capacity of individuals and individual families.
>
> We must promote—to the best of our ability and by all possible and appropriate means—the mental and physical health of all our citizens. (Kennedy, 1963, pp. 13–14).

Eleven years have elapsed since this statement was issued and various systems, programs, and techniques have been tried. Some have been successful, some have failed. Today, many community and residential services cannot meet acceptable levels or standards of programming. In 1960, there were 160,000 retarded persons in public residential facilities for the mentally retarded and 53,000 in private residential facilities and mental hospitals (President's Panel on Mental Retardation, 1962). By 1969, the number of retarded persons had increased to 190,000 in public residential facilities and 65,000 in private facilities and mental hospitals (Office of Mental Retardation Coordination, 1972). While there has been a major effort over the past several years to reduce residential populations, many persons have been transferred to inappropriate, under-programmed community facilities.

Deinstitutionalization

All states are attempting to meet the needs of retarded citizens and, at the same time, resolve some of the critical problems confronting most residential facilities through the dual processes of deinstitutionalization and institutional reform. The primary emphasis of this discussion will be upon deinstitutionalization.

Deinstitutionalization encompasses three interrelated processes: (a) prevention of admission by finding and developing alternative community methods of care and training, (b) return to the community of all residents who have been prepared through programs of habilitation and training to function adequately in appropriate local settings, and (c) establishment and maintenance of a responsive residential environment which protects human and civil rights and which contributes to the expeditious return of the individual to normal community living, whenever possible. In contrast institutional reform involves a modification or improvement in attitudes, philosophies, policies, effective utilization of available resources, and increased financing to provide adequate programs to motivate and assist individuals to reach their maximum level of functioning in the least restrictive environment possible (National Association of Superintendents of Public Residential Facilities for the Mentally retarded, 1974, pp. 4–5).

The Community

In order to establish a model from which to proceed, this discussion will emphasize (a) the community, (b) the residential facility, and (c) the mechanics through which each can assume its proper roles and functions. The term "community" can be considered from two points of view: (a) the socio-political community, and (b) the individual's community. Socio-political definitions of a community usually refer to a group of persons with some common background residing within a relatively restricted geographical area:

> A community is "a social group of any size whose members reside in a specific locality, share government, and have a common cultural and historical heritage" (Stein and Urdang, 1967, p. 298).
>
> A community is "a general population having a common interest or interdependency in the delivery of services" (NARC Residential Services and Facilities Committee, 1973, p. 72).

The individual's community is concerned with the experiences and mobility that he has within the socio-political community and his interactions with the people, services, and facilities contained within. Normally, the individual's community is smaller than the socio-political community as defined.

The residential facility's community also can be considered within the dual context of a socio-political area and its individual interactions. As shown in Figure 1, the residential facility exists within a socio-political community and may be part of the individual's community if he uses the services available. Although a residential facility may be located within or near a socio-political community, its services may extend to a number of such communities or, in some cases, throughout the state. Finally, communities also exist within the framework of a larger societal structure (county, state, and nation), all of which may influence to some degree each community and its inhabitants.

By definition (and practice) a residential facility must be considered an integral part of any community. The degree to which it is a successful member of that community depends upon the degree of its involvement and interaction.

The community that is available to the retarded should offer the "least restrictive environment;" however, placements in foster homes, group homes, or nursing homes, frequently are more restrictive than residential living in a public facility. For example, Murphy, Pennee, and Luchins (1972) studied foster home programs in Canada and concluded:

1. There was very little interaction between residents and family. In fact, one of the authors observed that in most homes there was not merely "a lack of interaction, but a lack of *any* activity whatever" (p. 5).

2. Regimentation and uniformity were common, e.g., certain days were set aside for shaving and others for bathing.

3. In many cases, there was no interaction between residents and other persons or facilities within the community.

Luchins summarized his observations by stating:

> . . . it is my opinion that those who think foster home placement enables a patient to escape the disadvantages of an institutional life are mistaken. Foster homes can be as institutionalized as hospitals are, while lacking the compensatory advantages that some hospitals might possess (p. 14).

Time magazine (1973, p. 74) described deinstitutionalization experiences in California:

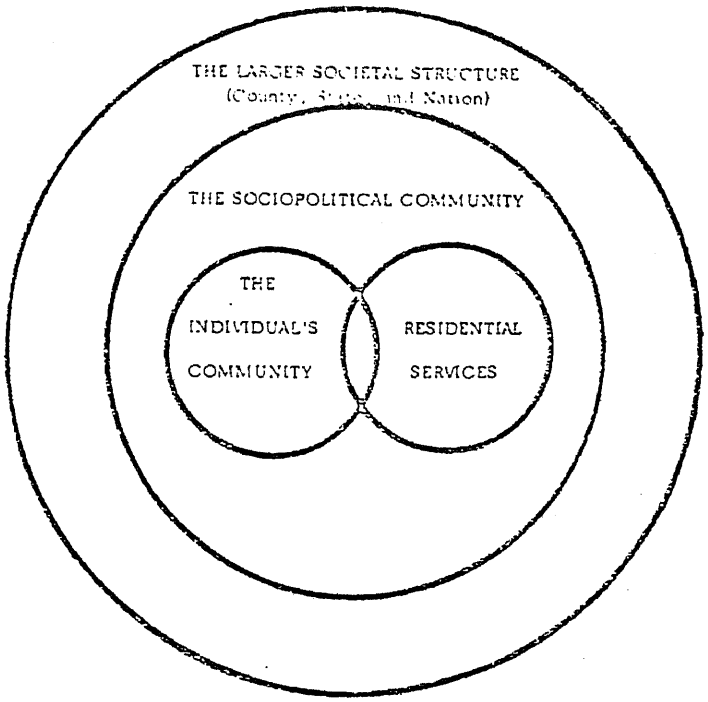
> . . . . chronically ill patients have been returned to communities poorly equipped to provide adequate treatment. With no one to care for them, former patients have ended up on welfare rolls, in boarding houses, cheap hotels, and even jail.

and in New York:

> . . . since New York state started emptying its mental hospitals of thousands of inmates six years ago, many of them have been jammed into tiny rooms, basements, and garages, and fed a semi-starvation diet of rice and chicken necks, . . . they are taken from the steps of mental institutions by operators who jam them into what can only be described as a private jail and confiscate their monthly welfare checks.

FIGURE 1

THE INTERRELATIONSHIPS OF COMMUNITIES



While it cannot be ascertained whether *Time* was referring to the mentally retarded as well as to the mentally ill, the circumstances associated with many of the placements of the retarded over the past several years have been similar.

These comments are not made to condemn the idea of community placement for retarded persons. Nor are they intended, in any way, to justify inadequate practices or services in residential facilities. These statements do, however, clearly demonstrate that any program, regardless of the facility or location in which it is being implemented, must be assessed only in terms of individual needs. According to the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974, pp. 2–3):

> While the Association advocates without reservation the rights of the retarded to live in the least restrictive environment and to enjoy fully the benefits of a free and open society whenever possible, it does express concern over the manner in which this goal is being realized. First, the quality of community programs and services being offered to the mentally retarded and other developmentally disabled persons in many parts of the country is inadequate. All too often, "community back wards" and "closeting" are being substituted for institutional "warehousing". Neither community nor residential back wards or "closeting" are justified: the rights of the retarded must be respected wherever they reside. In essence, the Association calls attention to the need not only for continued upgrading of residential facilities . . . but also for a greater interest in quality control for developing community programs.

Roles and Functions

The respective roles and functions of the community and one of its agencies, the residential facility, are outlined in Table 1. No attempt has been made to record all services which should be available. Extensive listings can be found in a number of publications, e.g., President's Panel on Mental Retardation (1962) and the NARC Residential Services and Facilities Committee (1974).

Community services listed have been divided into two categories: those which *must* be available and those which *should* be available. Services which *must* be available include an adequate living environment, health services, training and education if appropriate, some form of employment for older retarded persons, and mobility. The latter is important. The individual not only should be in a position to move freely within the community, but should be trained and encouraged to do so whenever possible, consistent with his needs and desires. Some operators of group and nursing homes are hesitant to permit residents to leave the premises in fear of potential liability suits or negative public reaction in the event of an accident.

Services which should be available, include any service offered to the general citizenry. The distinction between what must be and what should be available is important. Occasionally, one will encounter residential staff who believe firmly that a retarded person should not be returned to the community until all desired services are developed. Under such circumstances, few retarded persons would ever leave the residential setting. In essence, one has to weigh the advantages of increased opportunities for independence, freedom, and privacy against those residential programmatic offerings which might be lost by an individual when placed in the community.

If the community is capable of providing primary services and programs required by retarded persons, what will be the future role of a residential facility? It can be summarized in one word—specialization.[1] It is anticipated that most residential facilities will function as regional centers, offering specialized short-term, intensive treatment programs; specialized extended care and developmental training for severely and profoundly retarded, multiply handicapped persons; and specialized back-up and consultancy services. One of the primary functions of the residential facility in the future will be to prevent institutionalization.

[1] The position statements of the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974) include a more comprehensive discussion of the future role of residential facilities.

TABLE 1

BASIC COMMUNITY AND RESIDENTIAL SERVICES

COMMUNITY SERVICES

SERVICES WHICH MUST BE AVAILABLE:

1. Adequate home-like environment:
   - A. Natural home
   - B. Foster home
   - C. Group home
   - D. Nursing home
   - E. Independent living facility
2. Health services
3. Education and training
4. Employment (open or sheltered)
5. Mobility

SERVICES WHICH SHOULD BE AVAILABLE:

1. Recreational
2. Religious
3. All other services available to any citizen, e.g., commercial, welfare, family counseling, and protective.

RESIDENTIAL SERVICES

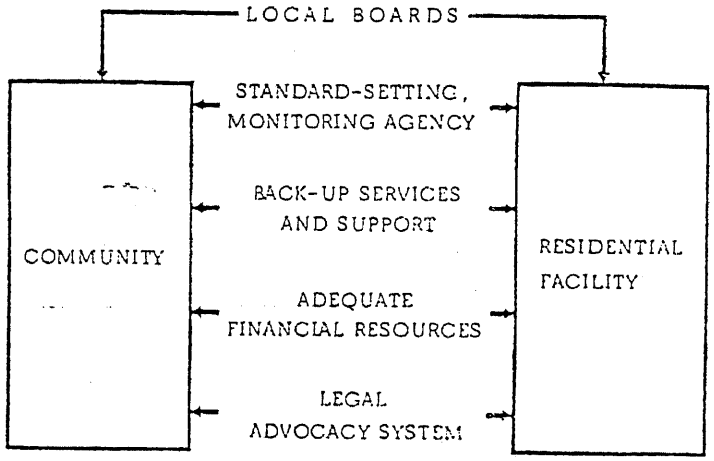
1. Specialized Diagnosis and Evaluation
2. Specialized Short-Term Training and Treatment Program
3. Specialized Extended Care
4. Specialized Back-Up and Technical Consultancy Services

Successful Deinstitutionalization—Five Integrants

The development of adequate community programs for the retarded, the return of many retarded persons to non-residential settings, and the realization of appropriate roles and functions by both the community and residential facility require five integrants. These are shown in Figure 2.

FIGURE 2

INTEGRANTS TO EFFECTIVE PROGRAMMING



1. There must exist on a local or regional level a visible agency or body with *statutory* authority to plan, implement, and coordinate programs for the retarded. These agencies must be *legally* accountable for services offered to the retarded in general and each individual in particular. (Wisconsin recently passed legislation to create community boards on a county level with the full authority, responsibility, and accountability to provide the 16 services associated with the Federal developmental disabilities act—P.L. 91–517: evaluation, diagnosis, treatment, day programs, training, education, sheltered employment, recreation, personal care, domiciliary care, special living arrangements, counselling, information and referral, follow-up, protective and other sociological services, and transportation. As of January 1, 1974, all state funds, excluding those for public schools and public residential facilities, were channeled through those boards and their professional staffs. There is nothing new about the concept of local boards. Many states have tried similar arrangements, usually with minimal success. The difference is that in Wisconsin the boards have statutory sanction and control over funding. Since their establishment there has been considerable local activity in providing a variety of services to the retarded and other developmentally disabled persons.)

2. An independent standard-setting and monitoring agency must be created. This can be accomplished in several ways: by establishing within the state an independent standard-setting group; by assigning such a task to a state agency; or by requiring accreditation through the Accreditation Council for Facilities for the Mentally Retarded. The essential ingredient is that the setting of standards and their evaluation reflect only the needs of the retarded. Inadequate programs should be given an opportunity to improve; however, if the required improvements are not evidenced according to a set schedule, funding should be terminated. While local boards would not set standards, they would retain responsibility and accountability to see that such standards were met.

3. Local boards and agencies must have access to quality back-up services, including technical consultancy. Many communities will require the expertise of persons who have had extensive experience in dealing with the mentally retarded. Hopefully, residential staff, university personnel, and representatives from established community agencies will pool their talents in a collaborative effort to provide the retarded with the finest programming possible.

4. All community programs, including residential, must receive substantial financial support. Neither the community nor its residential facility can provide for the retarded unless it has access to an adequate resource of funding for programming, training, and research. *Quality services are costly, regardless of where they are offered!*

5. There must exist a tough-minded, strong-willed advocacy program. Three systems have been proposed: (1) legal, (2) agency, and (3) citizen. A system of legal advocacy emphasizes the rights of retarded persons and relies primarily on legally trained advocates. The agency advocacy approach, in contrast, vests broad protectorship in a state department or agency. Protectors, who usually are behaviorally trained professionals, have responsibility to "provide guidance, service, and encouragement in the development of maximum self-reliance to a mentally retarded or other developmentally disabled person, independent of any determination of incompetency" (Ohio . . . . 1972, p. 7). Citizen advocacy according to Wolfensberger (1972, p. 12), is defined as "a mature, competent citizen volunteer representing, as if they were his own, the interest of another citizen who is impaired in his instrumental competency, or who has major expressive needs which are unmet and which are likely to remain unmet without special intervention."

Of these three systems, all of which have distinct value, the legal approach is most critical at this time. The retarded should share the same advantages and responsibilities as any other citizen in our society; in other words, their rights must be recognized. The question of individual rights is a legal matter which can best be represented by professionals of that discipline. As stated by Gilhool (1973, p. 53):

> The language has changed. It is no longer the language of favor or benefit. It is no longer the fact that what comes to the retarded child and his family comes out of the good will and the graciousness of others. It is now the language of rights. What comes, comes as a right. It is really not the language of love and kindness but of justice.

When the rights of the retarded have been clearly enunciated and understood by all, then, they can be represented more effectively by parents and other advocates with various experiential backgrounds. Until that time, the legal advocacy system should receive priority.

Reform

Deinstitutionalization is both desirable and feasible. A successful program of deinstitutionalization, however, will require institutional reform, community reform, and juridical reform, and legislative reform. Each residential facility must reassess its philosophy and services to insure that every resident is receiving a total developmental program, individually designed, intended to facilitate community return. Further, residential services, including technical consultancy, must be extended to the community at large to assist in developing local programs and averting the need for extended residential placement, whenever possible. The community, in turn, must express a greater willingness to include the retarded in the mainstream of everyday life and make a concerted effort to provide adequate services. The juridical system must recognize and protect the rights of the retarded and respond to existing inequities with alacrity. Legislators, at both state and national levels, also must recognize and protect the rights of retarded and provide those laws and resources necessary to enable them to live as full and rich a life as possible within the total society.

Summary

Deinstitutionalization is a desirable aim for all but a few retarded persons, and it can be attained within a relatively short period of time. The needs and rights of the retarded must be recognized and honored in both the community and residential setting. Although there has been considerable reform among many agencies and professions serving the retarded over the past several years, much remains to be accomplished. We have yet to "bestow the full benefits of our society on those who suffer from mental disabilities."

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From LOS ANGELES to LONG ISLAND . . .

Introduction

A management problem faced by the Indiana Department of Mental Health is to determine the population forecast of the state mental hospitals and use this statistic in seeking funds from the Indiana General Assembly. The 1975 General Assembly provided staff increases based upon the Wyatt-Steckney standards and the previously developed 1979 population forecast.

The objective of this study is to forecast the average daily population in the twelve state mental hospitals for FY77 through FY81. This study should be based upon a review of the literature, an analysis of existing data, assumptions that can be identified, and sound forecasting methodology. This forecast will be used by the Department in preparing its budget for the 1977 Indiana General Assembly.

Review of Pertinent Literature

The resident population in state and county mental hospitals (serving primarily the mentally ill) during the ten year period of 1945-55 increased to a high of 558,922 at the end of 1955.[1] There has been a continued reduction in the patient census, and the provisional data for Fiscal 1975 is 193,436.[2] This is a 10.3 percent drop from the previous year.

The following are some factors that have influenced this decrease in state hospital population.[3]

These factors, which operate to a greater or lesser extent in every State in the Nation, include: Increased availability and utilization of alternate care facilities for the aged; increased availability and utilization of outpatient and aftercare facilities; gradual reduction in the length of stay of admissions; introduction of community mental health centers; affiliation of community mental health centers with state mental hospitals; introduction of more effective screening procedures to prevent inappropriate admissions, administrative changes such as the introduction of the geographic unit system; and deliberate administrative efforts to

reduce the resident population. These factors are, of course, highly interrelated and affect the rates of admission, readmission, and duration of stay which, in turn, generate changes in the resident patient population.

Great Britain has also experienced a decline in their state hospital population.[4] McAtee and Zinkle feel that state hospitals should develop a new role as a center for human services and state hospitals will continue to be an important part of the mental health delivery system.[5] The closing of state hospitals and the reduction of patients' census has caused some feelings that many of these ex-patients are not receiving proper care.[6]

The population in public institutions serving the mentally retarded peaked at 193,121 resident patients in 1968 and declined to 185,855 in 1971.[7] A prediction by Wolfensberger suggests that the relative need for long-term residential placement for the mentally retarded will be reduced.[8]

The Conklin and Taylor report forecasts a reduction in the patient census in the Indiana State Mental Hospitals.[9] The Indiana State Budget Agency has forecasted a decline in these hospitals by using an exponent smoothing method. Charts One, Two, Three and Four show the actual decline in population. The FY75 "Official" forecast had an error percentage of 1.3% and this error percentage increased to 2.67% for FY76. (See Charts Five and Six.) However, it is the investigator's opinion that a three (3) or four (4) percent error is accurate enough for this type of forecasting.

Assumptions for the Indiana State Mental Hospital Delivery System

1. The General Assembly will not decide to close a state hospital by 1981.

2. There will be sufficient funds appropriated by the Federal, State and local legislative bodies to construct and operate the planned 32 com-

munity mental health centers. Monies will be available to operate houses for the mentally ill, day and residential services for the mentally retarded and developmentally disabled, and outpatient and residential services for those persons with addiction problems.

3. A national health insurance program should have an impact in lowering the number of patients served in state mental hospitals. This insurance program with mental health benefits will become law by June, 1978. The full impact of this program will be felt by state hospitals by January, 1980.

4. Mandatory special education in the public schools will reduce the number of emotionally disturbed school age children and adolescents entering the state hospital system. A similiar effect will also occur for mentally retarded children and adolescents.

5. There will be a gradual increase in the number of current state hospital patients placed on Family Care status.

6. The incidence and prevalence of mental illness, mental retardation and other developmentally disabilities, alcoholism and drug abuse will continue at the current rate.

7. There will be a constant proportion of the State's population at high risk (the poor and socially disadvantaged, unemployed, and others) which produce state hospital patients at a high rate.

8. There will be increased acceptance of the mentally ill person, the mentally retarded and developmentally handicapped individual, the alcoholic, and the drug abuser in his or her home community when proper treatment and supportive services are available.

9. The mental health service delivery system, both state hospital and community components, will become increasingly more effective, efficient,

and productive which will result in a reduced need for long-term state hospital care and treatment, plus the average length of stay in a state hospital will be reduced.

The investigator should state that there is disagreement among mental health professionals on such assumptions and if there is agreement on an assumption, then there would be differences of opinion on how this assumption would influence the future population of a state hospital.

The Forecast

The review of national and Indiana data, the survey of relevant literature, and the stated assumptions indicate that the number of patients in state hospitals is declining and it is expected that this trend will continue. Four quantitative forecasting methods will be used to better determine the slope of the anticipated decline.

Semi-logarithmic Method

The average daily population for the years FY67 through FY76 were plotted on semi-logarithmic graph paper (Chart Three). The slope was extended to FY81 and the forecasted average daily population are the following: FY77 6,385; FY78 5,838; FY79 5,338; FY80 4,881; and FY81 4,463.

Cohort Survival Method

Chart Seven demonstrates the cohort survival method of demographic forecasting. This method follows a group of patients over time and forecasts how many should survive or remain in the state hospital population. Column #2 of Chart Seven shows the number of patients enrolled by length of stay in the Indiana state hospital system as of June 30, 1971 (FY71). Column #3 shows the June 30, 1976 (FY76) enrollment by length of stay after five years.

The survival ratio is computed by dividing the FY76 enrollment (Column #3) for a five year length of stay by the number in the preceding five year length of stay in FY71 (Column #2). For example, there were 5,075 patients enrolled with a length of stay of 0 under 5 years on June 30, 1971, and after five years, 1,362 of these patients remained in the state hospital system by June 30, 1976. The figure 1,362 divided by 5,075 yields .2684.

There were 19,178 admissions for FY72 through FY76, but only 3,999 of these patients remained in the 0 under 5 years category.

The June 30, 1976 enrollment is multiplied by the survival rate for the next five year length of stay category and when totaled gives the June 30, 1980 forecast of patients enrolled. For example, there were 3,999 patients enrolled in the 0 under 5 years length of stay category on June 30, 1976, and the survival rate for the 5 years under 10 years length of stay is .2684. The forecast is 1,073 patients enrolled on June 30, 1981, with five years but less than ten years of continuous stay in the state hospital system.

There should be approximately 19,500 admissions for this five year time period of FY77 through FY81 (See Chart Eight). The forecasted 19,500 admissions are multiplied by the .2085 survival ratio (0 under 5 years) which produces the 4,066 forecasted patients enrolled for the 0 under 5 years category on June 30, 1981.

The forecasted enrollment for FY81 is 8,418. This is a reduction of 1,913 from the actual FY76 enrollment of 10,331 or a forecasted drop of 383 for each of the remaining five years. (This assumes that the reduction will be constant.) Thus, the forecasted patients enrolled would be the following: FY77 9,950; FY78 9,567; FY79 9,184; FY80 8,801; and FY81 8,418. When one

subtracts a 3,520 constant (See Chart Eight) between patients enrolled and average daily population, the following becomes the forecasted average daily population: FY77 6,430; FY78 6,047; FY79 5,664; FY80 5,281; and FY81 4,898.

Component Method

Chart Eight shows the component method which is also from the field of demography. One can forecast the end of the fiscal year enrollment by adding the anticipated admissions and subtracting discharges and deaths from the known enrollment at the start of the fiscal year. (The July 1st patients enrolled is the June 30th enrollment of the preceding fiscal year.) This process can be continued for each fiscal year to be forecasted.

The admissions, discharges, and deaths were forecasted for FY77 through FY81. The June 30, 1976 patients enrolled (an actual figure) becomes the July 1, 1976 enrollment. The anticipated 3,900 admissions were added to the 10,331 enrollment and the 284 projected deaths and 4,250 projected discharges results in the 9,697 forecasted June 30, 1977 enrollment. The 9,697 figure becomes the July 1, 1977 enrollment and this process continues.

The forecasted patients enrolled would be the following: FY77 9,697; FY78 9,097; FY79 8,527; FY80 7,984; and FY81 7,464. When one subtracts the 3,520 constant between patients enrolled and average daily population the following becomes the average daily population: FY77 6,177; FY78 5,577; FY79 5,007; FY80 4,467; and FY81 3,944.

Multi-Regression Method

The multi-regression statistical technique is used in business forecasting and is shown in Chart Nine. The dependent variable in this situation

is the average daily population. The independent variables are believed to cause the average daily population. The investigator developed different independent variables for those state hospitals primarily serving the mentally ill and those serving the mentally retarded and developmentally disabled. It was felt that such a division would produce a more accurate forecast than dealing with the system as a whole. There has been a different pattern of decline between those hospitals serving the mentally ill and those serving the mentally retarded and other developmentally disabled. (See Chart #2.)

The forecasted mentally retarded and other developmentally disabled (MR/DD) clients enrolled in state aided community programs and family care patients were developed with the program specialists in the Department responsible for such activities. Estimated data for outpatient terminations was used for FY75 and FY76 because a new data system was developed during FY75 and it appears the FY75 and FY76 data are not comparable with the previous information. The forecasted outpatient terminations were developed by the investigator based upon the actual and estimated time services data, plus knowledge of the development of the mental health centers. The multi-regression approach produced the following forecast: FY77 6,077; FY78 5,483; FY79 4,891; FY80 4,321; and FY81 3,751.

Results of Forecasting Methods

The following are the results of the four quantitative forecasting methods and the "Official" forecast. (See also Chart Ten.)

Average Daily Population (ADP)

Forecast Method	FY 77	FY 78	FY 79	FY 80	FY 81
Semi-Logarithmic	6,385	5,838	5,338	4,881	4,463
Component	6,177	5,577	5,007	4,467	3,944
Cohort Survival	6,430	6,047	5,664	5,281	4,898
Multi-Regression	6,077	5,483	4,891	4,321	3,751
"Official Forecast"	6,375	6,040	5,740	5,440	5,140

The results of the quantitative methods were taken into account in the preparation of the qualitative or "Official" forecast. It was felt that the decline experienced since FY68 will begin to plateau by FY81. Perhaps this judgement reflects the "art" in the forecasting process and the perceived dynamics of the Indiana mental health system.

Summary

There is a management need to develop an accurate population forecast of the Indiana State Mental Hospitals. Such a forecast would help reduce the uncertainty of the future average daily populations which is a key statistic to develop a budget for the Department. The available national and Indiana data shows a decline in state hospital populations. The identified assumptions and review of the literature leads the investigator to believe the decline to continue. Four quantitative methods were presented that assisted in the development of an "Official" or qualitative forecast.

The forecast is the first step in a forecasting, planning, implementation, and evaluation cycle. The anticipated impact of this forecast on the Department should be prepared. A forecast should be constantly monitored. The decisions made within the Department and by other agencies,

legislative bodies, and elected officials should be examined to see if they will influence the population of the state hospitals. One should examine this "what will happen" forecast and decide if the forecast is really "what should happen." A decision that an alternate future should be selected would lead to new planning, implementation, and evaluation activities that will change the forecast.

Both quantitative and qualitative forecasting methods are needed to make forecasts of state hospital populations which are used in the budget process.

Footnotes

The investigator is accountable for the logic and data errors in this paper, however, forecasting is a team effort within the Indiana Department of Mental Health and the whole staff roster could be listed as significantly helpful in the development of the forecast. Special recognition needs to be given to "Ike" Page, Ray Hedge, Marie Hisle, Sue Harris, Kathy Rouse, Phyllis Kern, and Russ Lingenfelter of the Statistics Office. Pamela Pope and Cynthia Brown provided invaluable secretarial assistance. Drs. Kaiomars P. Anklesaria and John T. Liell of the School of Public and Environmental Affairs, IUPUI, provided special counsel. Dr. Martin W. Meyer, Assistant Commissioner for Planning and Evaluation, provided his usual encouragement for professional development of his staff.

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[3]op.cit., page one and two.

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Chart #1

PATIENTS ENROLLED AND PATIENTS PRESENT, INDIANA STATE MENTAL HOSPITALS
BY MONTH, FISCAL YEARS 1967-1976

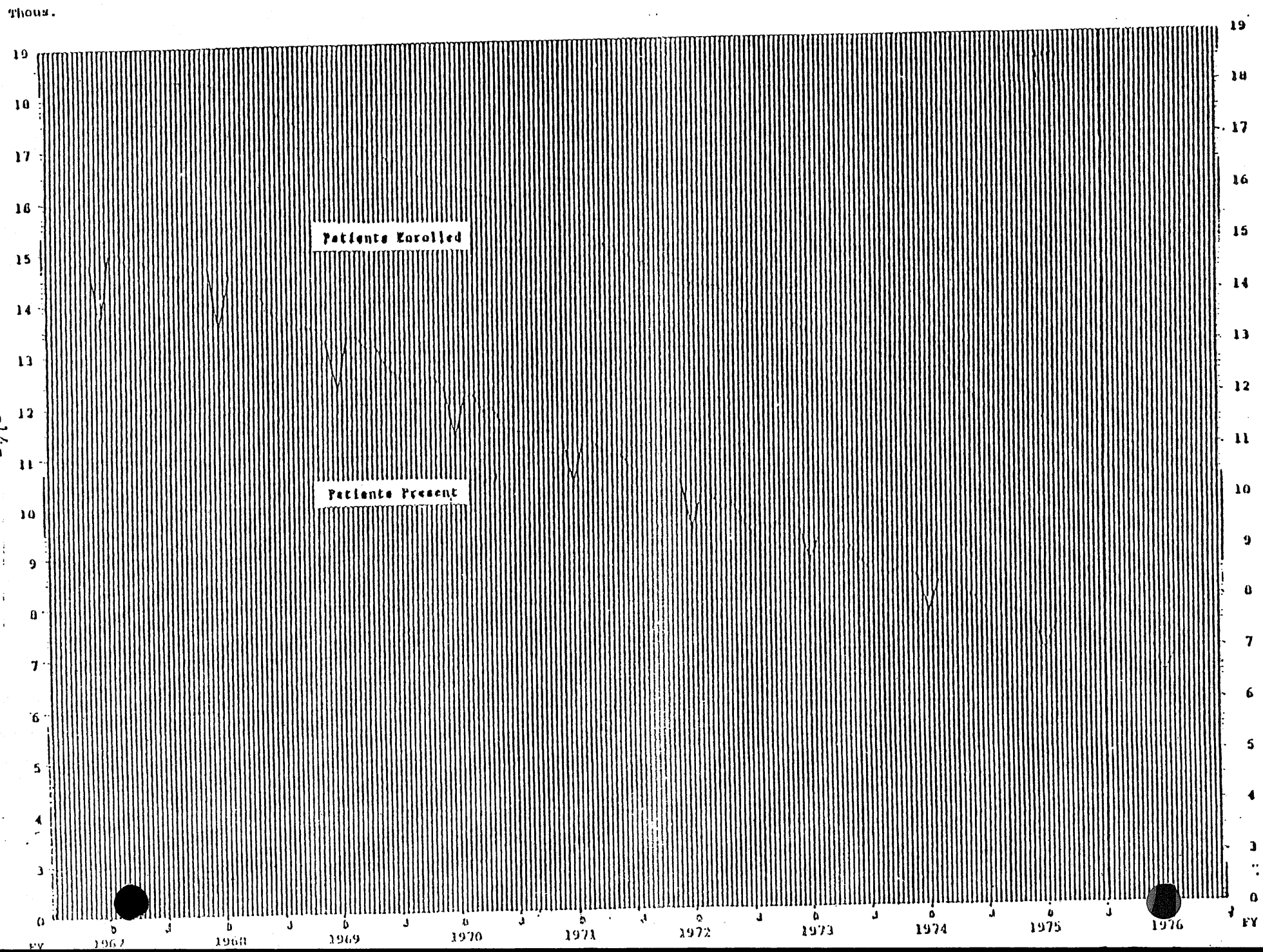
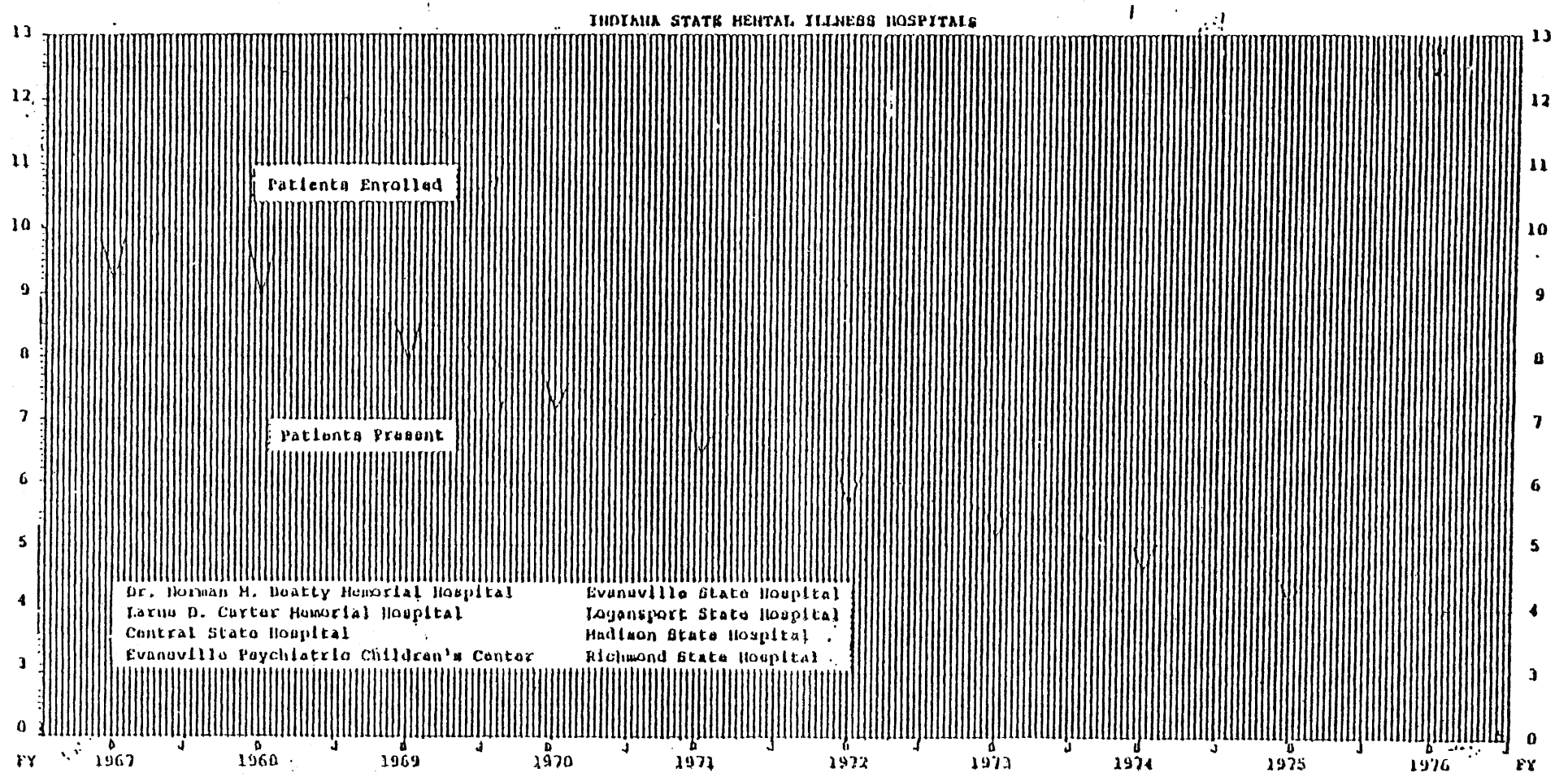
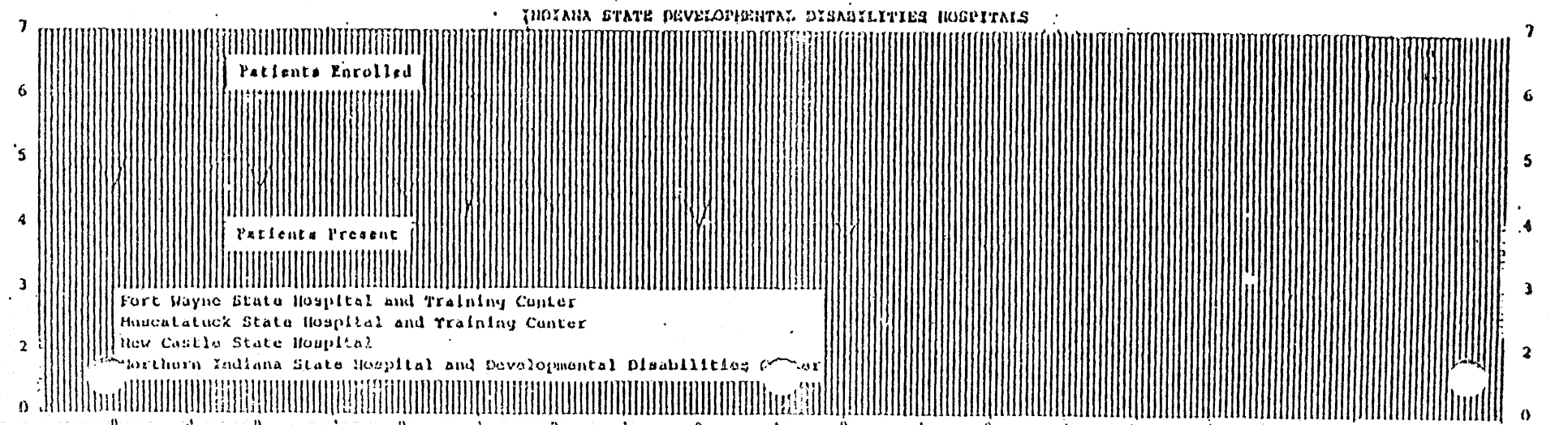


Chart #2

PATIENTS ENROLLED AND PATIENTS PRESENT, BY MONTH, FISCAL YEARS 1967-1976





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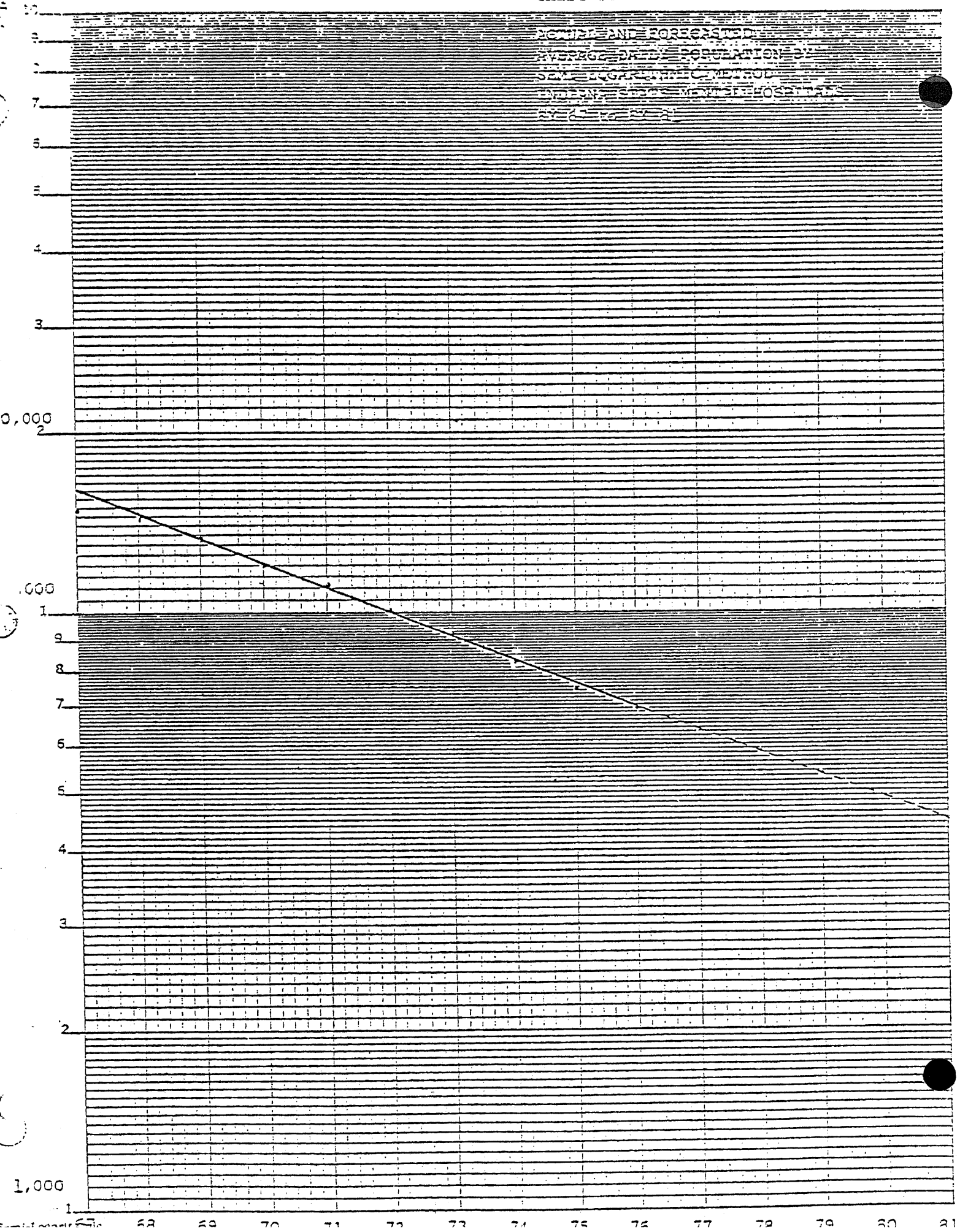
ACTUAL AND FORECASTED
AVERAGE DAILY POPULATION BY
SEMI-LOGARITHMIC METHOD
UNDERLING STATE MENTAL HOSPITALS
BY AGE GROUP
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Statistics Branch
Indiana Department of Mental Health
Released December, 1976

DEATH RATE PER 1,000 POPULATION OF SELECTED INDIANA STATE MENTAL HOSPITALS, FY67 TO FY76

	Fiscal Years Ending June 30									
Hospital	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty-Civil	.09	.07	.06	.05	.05	.04	.03	.04	.02	.02
04 Central	.17	.17	.17	.14	.07	.05	.06	.04	.02	.02
05 Evansville	.10	.13	.08	.09	.07	.06	.06	.07	.06	.04
06 Logansport	.27	.27	.20	.16	.15	.17	.13	.09	.14	.10
07 Madison	.19	.19	.15	.17	.14	.13	.12	.09	.11	.08
08 Richmond	.16	.18	.15	.10	.11	.09	.06	.07	.05	.03
TOTAL DEATHS	804	813	664	591	495	446	398	341	309	231
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Deaths per 1,000 population	.16	.16	.13	.11	.10	.09	.08	.06	.06	.04

Sources of data: FY 1967-1976 deaths - Indiana Mental Hospital Statistics, 1966-1976.
FY 1966-1969 Indiana population - Estimated population. State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U.S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U.S. Department of Commerce.

FORECASTING THE NUMBER OF PATIENTS IN INDIANA STATE MENTAL HOSPITALS BY 1981*

By

Donald B. Beeler, M.S.inEd.**

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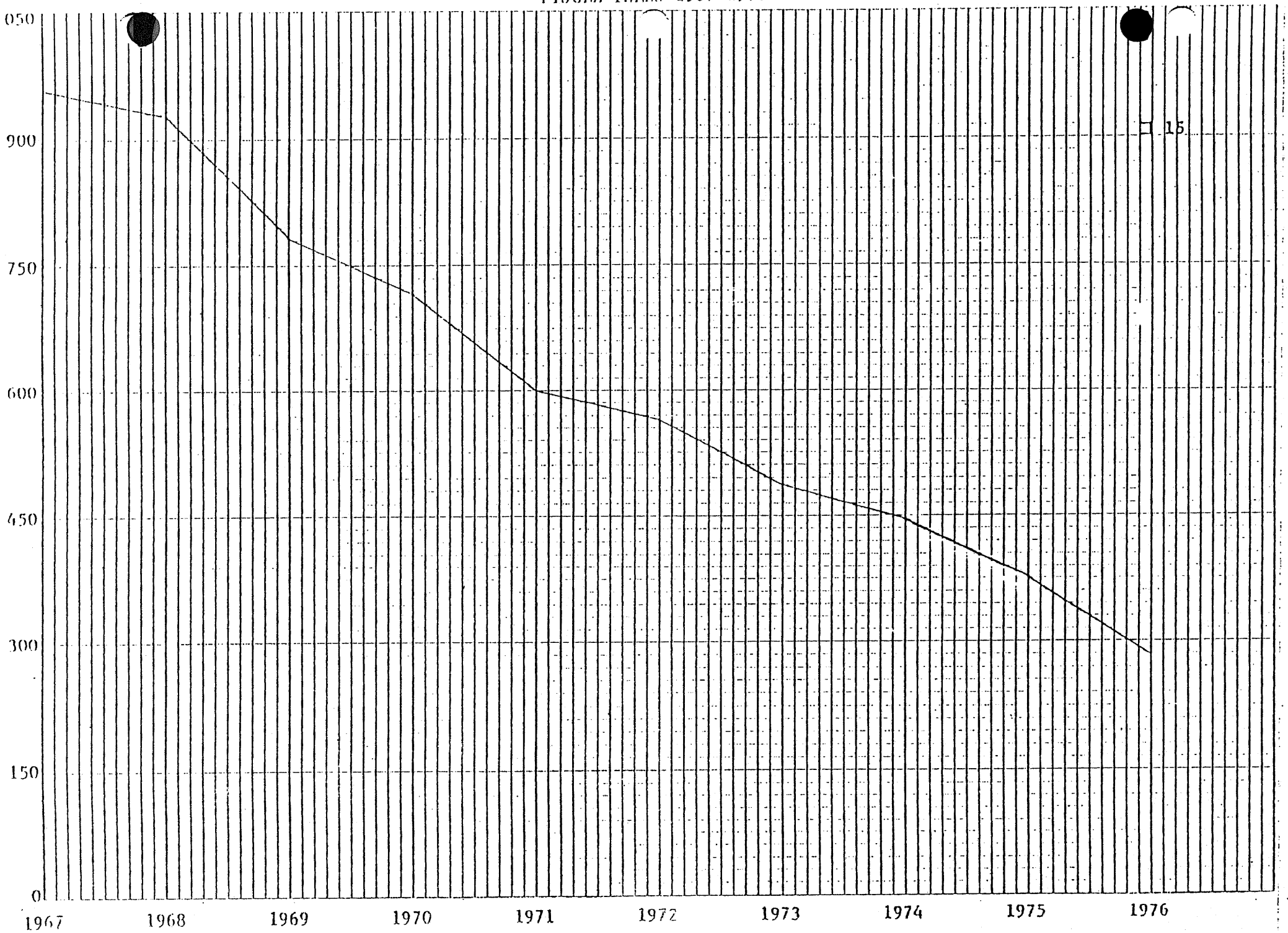
Statistics Branch
Indiana Department o ntal Health
Released December, 1976

INDIANA STATE MENTAL HOSPITALS
DEATHS
FISCAL YEARS 1967-1976

Hospital	Fiscal Years Ending June 30									
	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty-Civil	122	94	86	76	65	51	49	58	28	24
02 Beatty-MSD	7	5	9	5	2	3	0	3	0	0
03 Carter	3	0	1	3	5	3	0	2	0	0
04 Central	129	132	130	110	58	38	45	30	23	26
05 Evansville	49	64	37	44	36	31	32	35	39	26
06 Logansport	237	237	183	148	141	156	122	89	113	81
07 Madison	141	144	110	131	109	100	100	70	61	52
08 Richmond	126	142	118	82	86	70	50	59	37	22
55 Fort Wayne	56	44	36	57	44	48	27	41	24	17
56 Muscatatuck	43	25	29	25	24	32	31	31	19	17
58 Northern Indiana	7	12	15	5	10	6	9	2	2	2
59 New Castle	38	29	27	32	19	26	20	24	22	17
60 EPCC	0	0	0	0	0	0	0	0	0	0
TOTAL DEATHS	958	928	781	718	599	564	485	444	376	284
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Deaths per 1,000 population	.19	.18	.15	.14	.12	.11	.09	.08	.07	.05

Sources of data: FY 1967-1976 deaths - Indiana Mental Hospital Statistics, 1966-1976.
FY 1966-1969 Indiana population - Estimated population. State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U.S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U.S. Department of Commerce.

FISCAL YEARS 1967-1976



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DISCHARGE RATE PER 1,000 POPULATION OF SELECTED INDIANA STATE MENTAL HOSPITALS, FY67 to FY76

	Fiscal Years Ending June 30									
Hospital	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty-Civil	.46	.46	.47	.36	.36	.40	.40	.34	.42	.48
04 Central	.44	.66	.88	.85	.85	.75	.71	.72	.52	.52
05 Evansville	.94	.93	1.07	.89	.88	.81	.71	.57	.48	.60
06 Logansport	.97	1.03	.94	.71	.56	.54	.57	.52	.79	.61
07 Madison	.89	.80	.94	.70	1.27	.80	.77	1.17	.74	.96
08 Richmond	.65	.87	.87	.87	.86	.87	.66	.89	.77	.90
TOTAL DISCHARGES	3,383	3,795	4,111	3,532	3,808	3,369	3,194	3,540	3,193	3,432
Indiana Population(in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Discharges per 1,000 population	.69	.75	.81	.68	.73	.65	.60	.67	.60	.65

Sources of data: FY 1967-1976 discharges - Indiana Mental Hospital Statistics, 1966-1976.
FY 1966-1969 Indiana population - Estimated population, State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U.S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U.S. Department of Commerce.

Statistics Branch
Indiana Department of Mental Health
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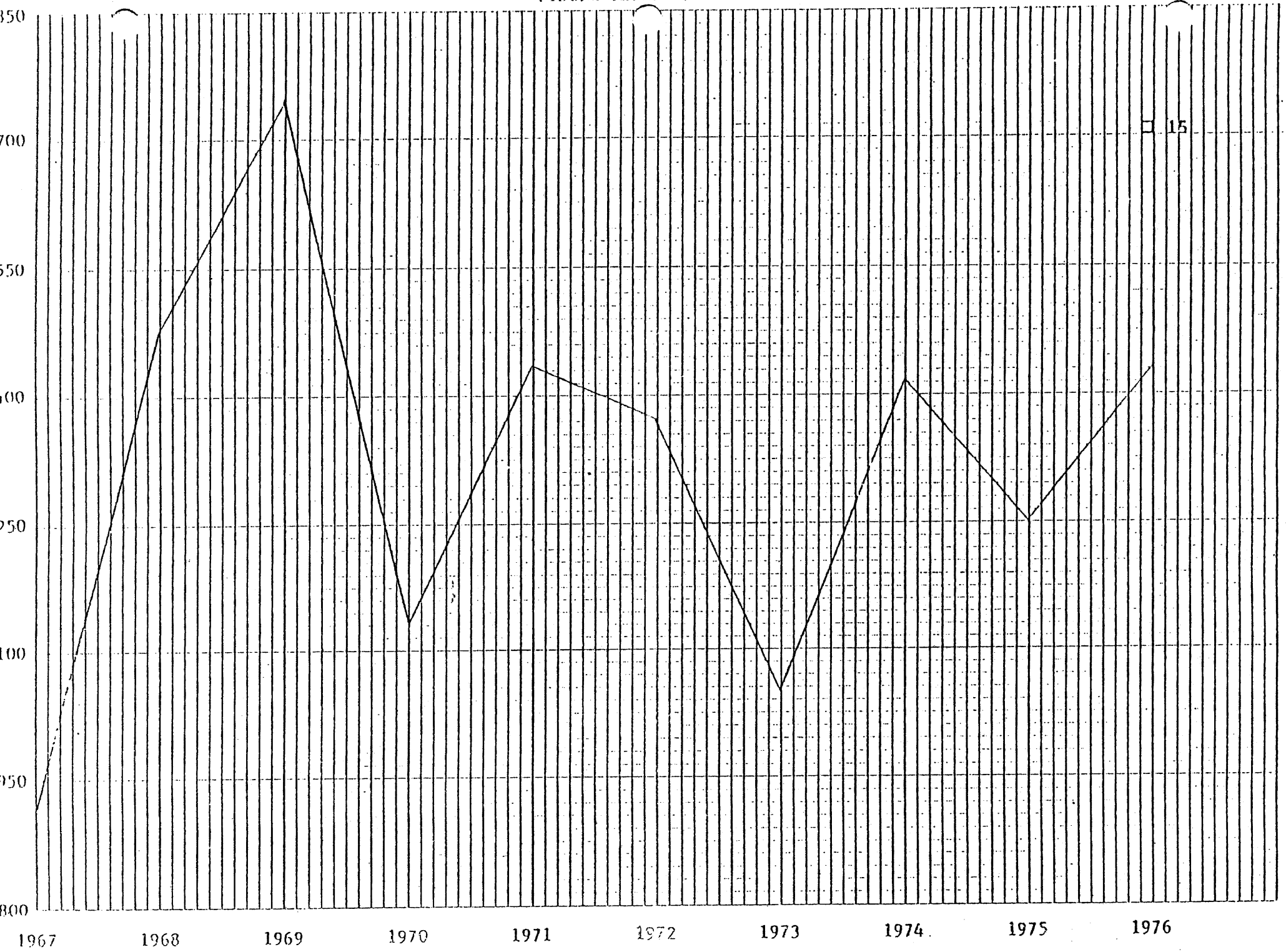
INDIANA STATE MENTAL HOSPITALS
DISCHARGES
FISCAL YEARS 1967-1976

	Hospital	Fiscal Years Ending June 30 1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01	Beatty-Civil	623	635	653	511	500	555	563	488	526	604
02	Beatty-MSD	81	53	145	82	96	205	99	107	138	121
03	Carter	326	386	310	323	342	395	362	352	403	422
04	Central	328	506	680	677	674	591	567	574	599	595
05	Evansville	449	453	523	435	431	397	356	283	316	391
06	Logansport	837	920	851	652	510	495	536	488	662	506
07	Madison	644	594	705	548	991	626	623	965	479	627
08	Richmond	502	687	699	709	702	705	549	742	611	708
55	Fort Wayne	26	112	94	100	131	247	217	223	237	185
56	Muscatatuck	64	100	56	49	32	92	103	79	125	122
58	Northern Indiana	1	1	5	1	0	2	10	7	26	28
59	New Castle	29	22	16	37	19	47	49	76	96	79
60	EPCC	2	8	9	9	8	16	15	32	32	43
	TOTAL DISCHARGES	3,912	4,477	4,746	4,133	4,436	4,373	4,049	4,416	4,250	4,432
	Indiana population(in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
	Discharges per 1,000 population	.79	.89	.93	.80	.85	.84	.77	.83	.80	.83

Sources of data: FY 1967-1976 discharges - Indiana Mental Hospital Statistics, 1966-1976.
FY 1966-1969 Indiana population - Estimated population, State Board of Health
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974(provisional), Current population reports, U.S. Department of Commerce.
FY 1976 Estimated population for 1975(provisional), Current population reports, U.S. Department of Commerce.

FISCAL YEARS 1967-1976



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PATIENTS PRESENT RATE PER 1,000 POPULATION OF SELECTED INDIANA STATE MENTAL HOSPITALS, FY67 TO FY76

Hospital	Fiscal Years Ending June 30									
	1966	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty - Civil	1.09	1.00	.86	.79	.77	.58	.66	.55	.53	.48
04 Central	2.87	2.63	2.14	1.71	1.34	1.22	.92	.82	.57	.48
05 Evansville	1.91	1.83	1.70	1.53	1.44	1.38	1.25	1.24	.96	.90
06 Logansport	2.27	2.05	1.87	1.64	1.57	1.39	1.28	1.15	1.09	1.02
07 Madison	1.70	1.57	1.47	1.29	1.18	1.10	.97	.85	1.11	.99
08 Richmond	1.78	1.51	1.32	1.16	1.04	.82	.77	.63	.61	.62
TOTAL PATIENTS PRESENT	9,106	8,461	7,538	6,662	6,059	5,255	4,910	4,350	4,059	3,714
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Patients Present per 1,000 population	1.85	1.68	1.48	1.28	1.17	1.01	.93	.82	.76	.70

Sources of data: FY 1967-1969 Indiana population - Estimated population, State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U.S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U.S. Department of Commerce.

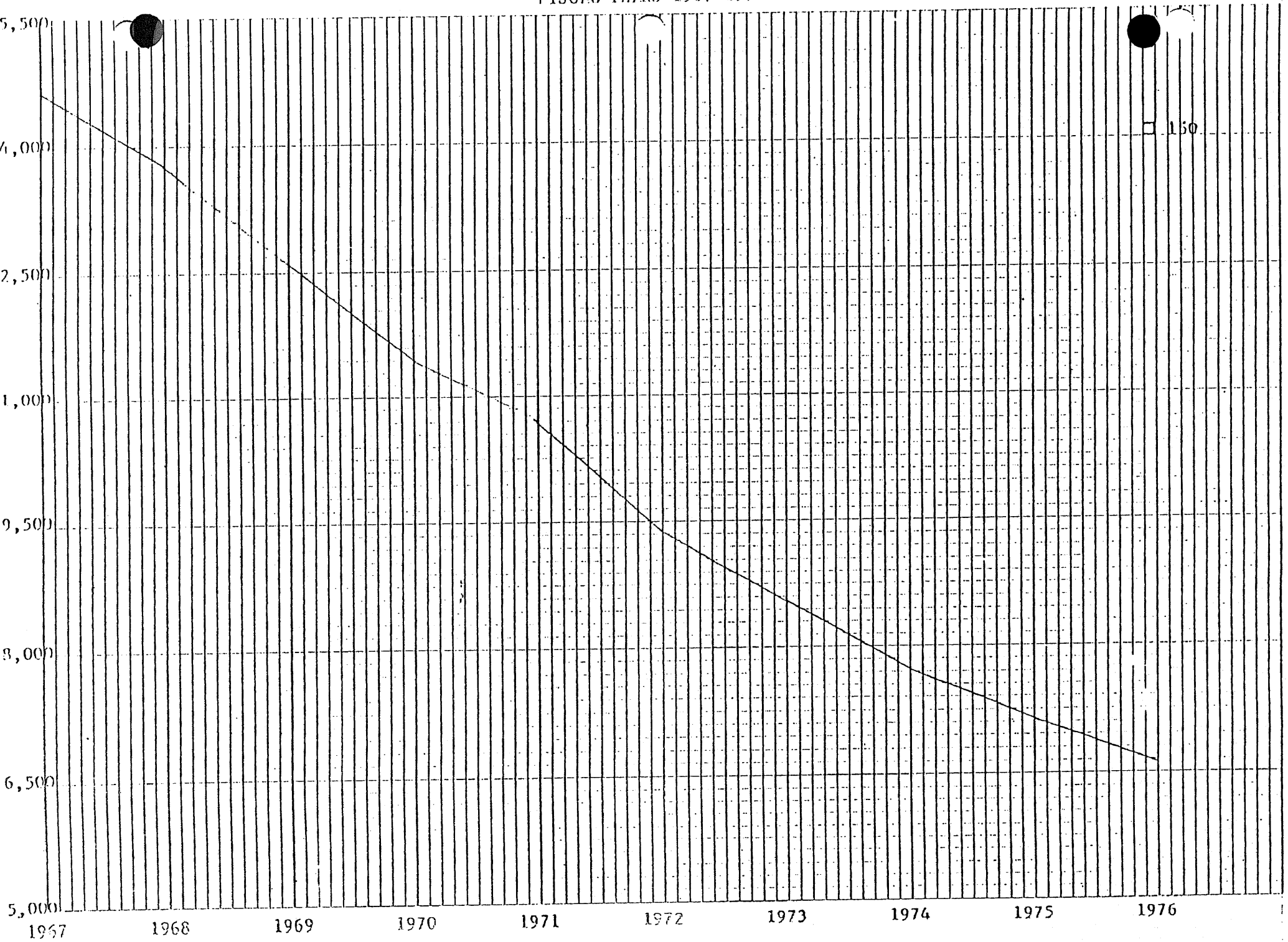
Statistics Branch
Indiana Department of Mental Health
Released December, 1976

INDIANA STATE MENTAL HOSPITALS
PATIENTS PRESENT
FISCAL YEARS 1967-1976

Hospitals	Fiscal Years Ending June 30									
	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty - Civil	1472	1377	1203	1106	1081	810	935	780	666	598
02 Beatty - MSD	494	501	339	307	280	218	146	123	124	133
03 Carter	170	137	135	148	140	128	106	145	128	123
04 Central	2163	2007	1658	1351	1065	968	734	651	655	555
05 Evansville	910	890	832	751	707	676	621	617	627	583
06 Logansport	1956	1830	1694	1500	1441	1274	1198	1081	905	844
07 Madison	1230	1164	1099	1008	921	858	786	699	719	641
08 Richmond	1375	1193	1052	946	844	669	636	522	487	493
55 Fort Wayne	2079	2120	2109	2023	1938	1645	1399	1247	1144	1055
56 Muscatatuck	1727	1602	1522	1432	1439	1330	1261	1210	1088	1033
58 Northern Indiana	158	115	140	149	144	137	121	92	86	86
59 New Castle	870	820	795	710	684	632	611	551	471	470
60 EPCC	19	20	21	24	22	18	19	17	17	23
TOTAL PATIENTS PRESENT	14,623	13,776	12,599	11,455	10,706	9,363	8,573	7,735	7,117	6,637
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Patients Present per 1,000	2.96	2.73	2.47	2.21	2.06	1.80	1.62	1.46	1.34	1.25

Sources of data: FY 1967-1969 Indiana population - Estimated population, State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U. S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U. S. Department of Commerce.

FISCAL YEARS 1967-1976



Statistics Branch
Indiana Department of [illegible]ta[illegible]alth
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INDIANA STATE MENTAL HOSPITALS
PATIENTS ENROLLED
FISCAL YEARS 1967-1976

Hospital	Fiscal Years Ending June 30									
	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty - Civil	2,029	1,960	1,839	1,755	1,752	1,548	1,446	1,366	1,267	1,075
02 Beatty - MSD	496	503	345	314	288	227	151	126	128	137
03 Carter	191	163	175	175	185	159	151	187	171	140
04 Central	2,493	2,324	2,030	1,670	1,376	1,251	1,029	923	903	795
05 Evansville	1,200	1,228	1,167	1,087	1,021	961	922	905	916	821
06 Logansport	2,415	2,296	2,137	2,041	2,045	1,926	1,877	1,918	1,659	1,637
07 Madison	1,852	1,935	1,935	1,990	1,589	1,570	1,508	1,109	1,236	1,183
08 Richmond	1,849	1,654	1,528	1,373	1,237	1,035	1,088	936	927	868
55 Fort Wayne	2,562	2,516	2,509	2,416	2,334	2,117	1,936	1,725	1,527	1,368
56 Muscatatuck	2,093	1,943	1,896	1,894	1,900	1,810	1,716	1,652	1,551	1,437
58 Northern Indiana	181	147	171	176	172	167	148	144	128	125
59 New Castle	978	970	948	910	903	863	869	780	706	721
60 EPCC	19	22	23	26	26	24	25	19	17	23
TOTAL PATIENTS ENROLLED	18,358	17,661	16,703	15,827	14,828	13,658	12,866	11,790	11,13[illegible]	10,330
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Patients Enrolled per 1,000 population	3.72	3.50	3.27	3.05	2.85	2.63	2.43	2.22	2.09	1.95

Sources of data: FY 1967-1969 Indiana population - Estimated population, State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U.S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U.S. Department of Commerce.

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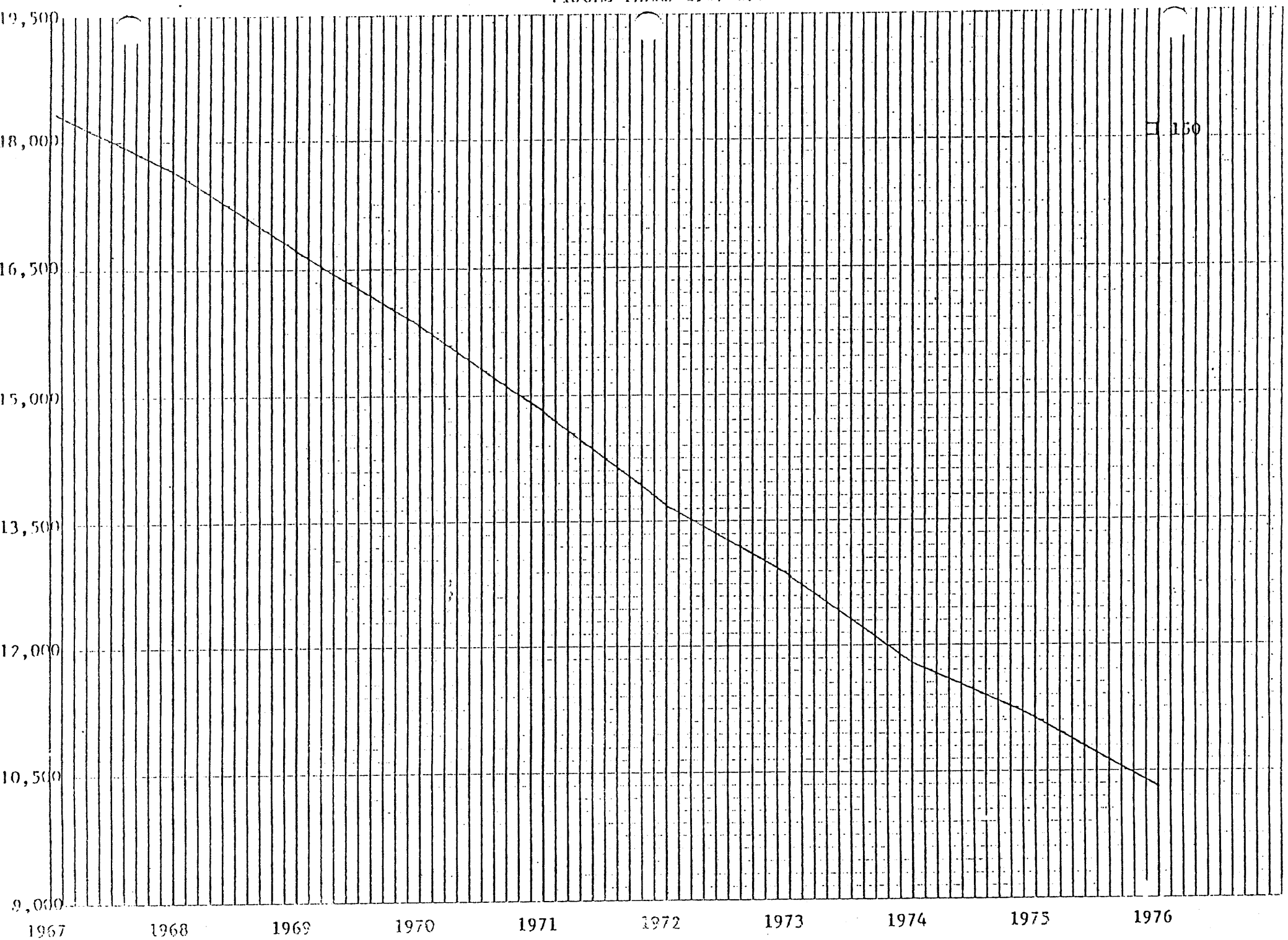
PATIENTS ENROLLED RATE PER 1,000 POPULATION OF SELECTED INDIANA STATE MENTAL HOSPITALS, FY67 TO FY76

Hospital	Fiscal Years Ending June 30									
	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty - Civil	1.51	1.42	1.32	1.25	1.25	1.11	1.02	.96	1.01	.86
04 Central	3.31	3.05	2.62	2.11	1.74	1.58	1.29	1.16	.79	.69
05 Evansville	2.52	2.53	2.38	2.22	2.08	1.96	1.85	1.81	1.40	1.27
06 Logansport	2.80	2.58	2.36	2.23	2.23	2.10	2.00	2.04	1.99	1.98
07 Madison	2.56	2.61	2.59	2.55	2.03	2.01	1.87	1.35	1.91	1.82
08 Richmond	2.40	2.09	1.91	1.69	1.52	1.27	1.32	1.13	1.17	1.10
TOTAL PATIENTS ENROLLED	11,838	11,397	10,636	9,916	9,020	8,291	7,870	7,157	6,908	6,379
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Patients enrolled per 1,000 population	2.40	2.26	2.08	1.91	1.74	1.60	1.49	1.35	1.30	1.20

Sources of data: FY 1967-1969 Indiana population - Estimated population, State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U. S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U. S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U. S. Department of Commerce

FISCAL YEARS 1967-1976



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Released December,

ADMISSION RATE PER 1,000 POPULATION OF SELECTED INDIANA STATE MENTAL HOSPITALS, FY67 TO FY76

	Fiscal Years Ending June 30									
Hospital	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty-Civil	.58	.48	.41	.36	.37	.28	.33	.31	.36	.34
04 Central	.60	.61	.66	.53	.55	.63	.49	.61	.51	.43
05 Evansville	1.07	1.12	1.01	.79	.82	.74	.70	.59	.55	.50
06 Logansport	1.21	1.16	.99	.78	.71	.60	.65	.65	.63	.68
07 Madison	.99	1.08	1.07	.93	.89	.90	.82	.77	1.04	.96
08 Richmond	.80	.79	.86	.77	.81	.70	.79	.78	.80	.87
TOTAL ADMISSIONS LESS TRANSFERS	4,115	4,125	3,968	3,377	3,358	3,077	3,127	3,125	3,225	3,122
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.[illegible]
Mean(average) Admissions per 1,000 population	.83	.82	.78	.65	.65	.59	.59	.59	.61	.59

Sources of data: FY 1967-1973 admissions - Indiana Mental Hospital Statistics, 1966-1973.
FY 1966-1969 Indiana population - Estimated population, State Board of Health
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U.S. Department of Commerce.
FY 1976 Estimated population for 1975 (provisional), Current Population Reports, U.S. Department of Commerce.

Statistics Branch
Indiana Department of Mental Health
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INDIANA STATE MENTAL HOSPITALS
ADMISSIONS LESS TRANSFERS
FISCAL YEARS 1967-1976

Hospital	Fiscal Years Ending June 30									
	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
01 Beatty-Civil	779	664	575	506	521	389	471	446	452	419
02 Beatty-NSD	118	63	40	83	109	161	77	123	152	154
03 Carter	354	384	329	332	367	371	352	393	402	403
04 Central	451	462	513	423	435	502	388	489	579	495
05 Evansville	509	542	496	385	400	364	347	296	363	327
06 Logansport	1,043	1,034	897	711	652	550	612	614	523	565
07 Madison	714	802	802	723	696	704	659	636	675	626
08 Richmond	619	621	685	629	654	568	650	644	633	690
55 Fort Wayne	50	53	102	58	92	64	59	59	59	53
56 Muscatatuck	169	29	55	69	64	45	85	39	45	34
58 Northern Indiana	7	4	44	11	6	3	2	5	11	27
59 New Castle	43	40	21	33	32	32	24	13	46	69
60 EFCC	20	10	10	12	8	14	16	26	30	48
TOTAL ADMISSIONS LESS TRANSFERS	4,876	4,708	4,569	3,975	4,036	3,767	3,742	3,783	3,972	3,910
Indiana population (in thousands)	4,933.0	5,049.0	5,105.7	5,193.7	5,193.7	5,193.7	5,291.0	5,316.0	5,330.0	5,311.0
Admissions per 1,000 population	.99	.93	.89	.77	.78	.73	.71	.71	.75	.74

Sources of data: FY 1967-1973 admissions - Indiana Mental Hospital Statistics, 1966-1973.
FY 1966-1969 Indiana population - Estimated population, State Board of Health.
FY 1970-1973 Indiana population - Bureau of the Census, U.S. Department of Commerce.
FY 1974 Estimated population for 1973, Current Population Reports, U.S. Department of Commerce.
FY 1975 Estimated population for 1974 (provisional), Current Population Reports, U.S. Department of Commerce.
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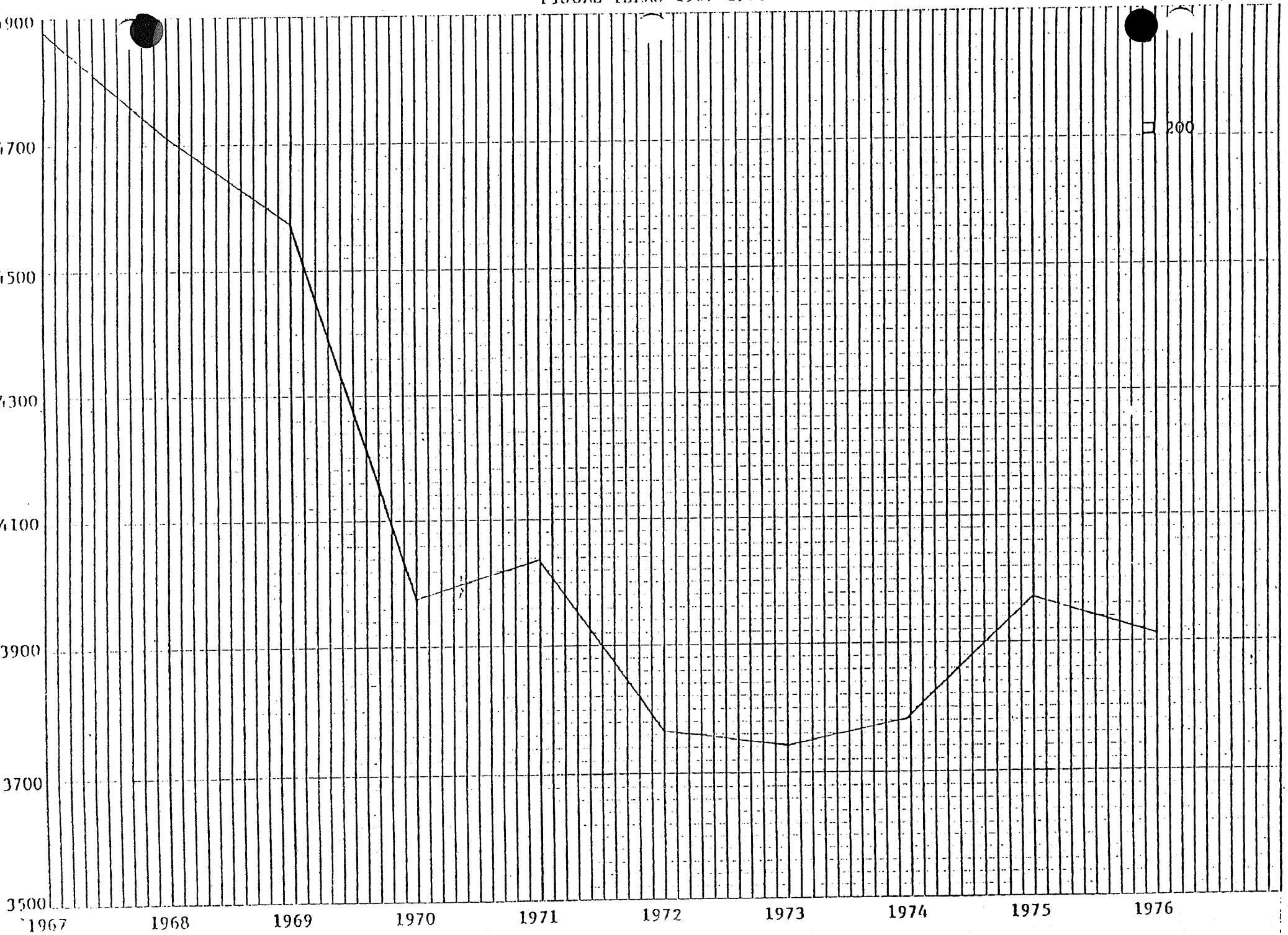
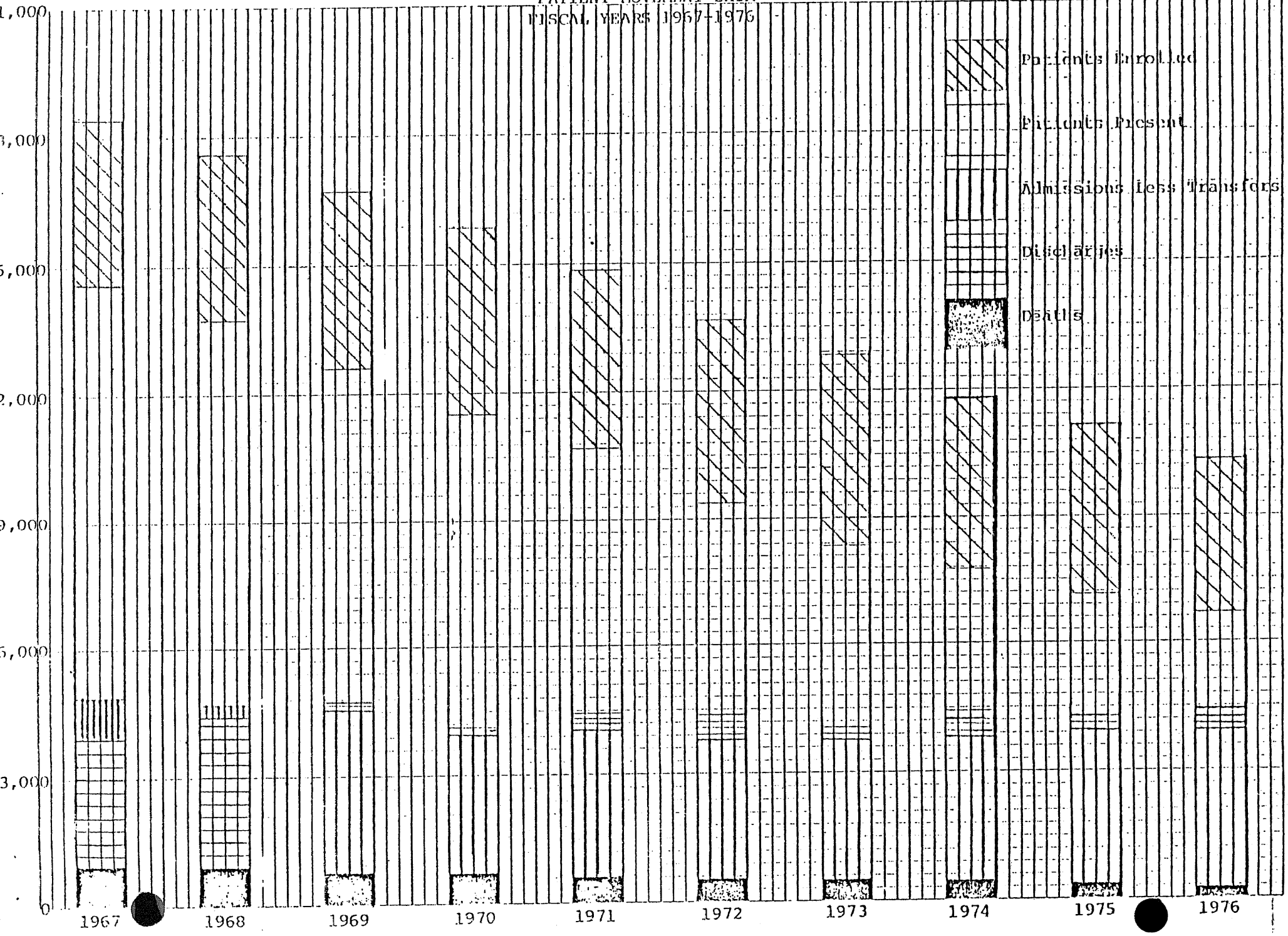
FISCAL YEARS 1967-1976



INDIANA STATE MENTAL HOSPITALS
PATIENT MOVEMENT DATA
FISCAL YEARS 1967-1976



State of Indiana
Otis R. Bowen, M.D., Governor

DEPARTMENT OF MENTAL HEALTH
FIVE INDIANA SQUARE
INDIANAPOLIS, INDIANA 46204

Commissioner
Deputy Commissioner
Deputy Commissioner
for Administration
633-7570

DIVISIONS:

Addiction Services
633-4477

Forensic Services
633-7591

Mental Illness
633-7526

Mental Retardation
& Dev. Disabilities
633-7562

Planning & Evaluation
633-7511

MEMORANDUM:

TO : Dr. Murray

FROM : Martin W. Meyer, Ed.D.
Assistant Commissioner for
Planning and Evaluation

SUBJECT : Patient Movement Data
Fiscal Year 1967 - Fiscal Year 1976

DATE : March 1, 1977

Attached are patient movement data including admissions, discharges, patients enrolled, patients present, and deaths for the State Hospital system. Also included are rates per 1,000 population of this data for the six district hospitals.

MWM:pp

Attachment

Chart #4

Comparison of Percentages of Admissions by Age less Transfers

for Selected Indiana State Mental Hospitals for FY67 and FY76

	Beatty Civil			Central			Evansville			Logansport			Madison			Richmond		
Age	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.
Under 15	4.7%	2.1%	-2.6%	3.5%	2.8%	-0.7%	1.4%	0.3%	-1.1%	3.7%	1.6%	-2.1%	1.1%	1.4%	0.3%	1.9%	1.3%	-0.6%
15 - 24	18.9	34.6	15.7	7.8	22.1	14.3	15.7	25.4	9.7	12.6	17.5	4.9	11.1	22.2	11.1	13.6	32.9	19.3
25 - 34	21.8	23.9	2.1	16.4	23.5	7.1	19.1	24.5	5.4	15.1	25.1	10.0	17.9	20.3	2.4	19.5	22.2	2.7
35 - 44	21.1	16.9	-4.2	22.8	23.1	0.3	23.6	19.3	-4.3	21.2	20.9	-0.3	21.6	21.1	-0.5	23.4	17.0	-6.4
45 - 54	17.0	13.4	-3.6	23.7	15.3	-8.4	18.9	13.5	-5.4	19.1	18.4	-0.7	15.5	14.7	-0.8	20.7	12.2	-8.5
55 - 64	9.9	6.4	-3.5	12.6	8.9	-3.7	13.0	9.5	-3.5	13.3	9.7	-3.6	14.0	10.1	-3.9	11.6	8.8	-2.8
65 - 74	4.0	2.4	-1.6	7.0	3.0	-4.0	6.0	6.7	0.7	7.6	4.1	-3.5	9.4	5.9	-3.5	5.2	4.9	-0.3
75 - 84	2.4	0.2	-2.2	4.4	0.6	-3.8	2.2	0.9	-1.3	5.9	1.9	-4.0	8.3	3.7	-4.6	3.7	0.7	-3.0
85 and over	0.1	0	-0.1	1.6	0.6	-1.0	0.2	0	-0.2	1.4	0.7	-0.7	1.1	0.6	-0.5	0.3	0	-0.3
Total Admissions less Transfers	779	419	360	451	497	-46	509	327	182	1043	565	478	714	626	88	619	690	-71

Chart #3

Comparison of Admissions less Transfers by Age for Selected

Indiana State Hospitals for FY67 and FY76

	Beatty Civil			Central			Evansville			Logansport			Madison			Richmond		
	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.
Under 15	37	9	28	16	14	2	7	1	6	39	9	30	8	9	-1	12	9	3
15 - 24	147	145	2	35	110	-75	80	83	-3	131	99	32	79	139	-60	84	227	-143
25 - 34	170	100	70	74	117	-43	97	80	17	158	142	16	128	127	1	121	153	-32
35 - 44	164	71	93	103	115	-12	120	63	57	221	118	103	154	132	22	145	117	28
45 - 54	133	56	77	107	76	31	96	44	52	199	104	95	111	92	19	128	84	44
55 - 64	77	27	50	57	44	13	66	31	35	139	55	84	100	63	37	72	61	11
65 - 74	31	10	21	32	15	17	31	22	9	79	23	56	67	37	30	32	34	-2
75 - 84	19	1	18	20	3	17	11	3	8	62	11	51	59	23	36	23	5	18
85 and over	1	0	1	7	3	4	1	0	1	15	4	11	8	4	4	2	0	2
TOTAL	779	419	360	451	497	-46	509	327	182	1043	565	478	714	626	88	619	690	-71

Chart #1

Comparison of Patients Enrolled by Age for Selected

Indiana State Hospitals for FY67 and FY76

	Beatty Civil			Central			Evansville			Logansport			Madison			Richmond		
	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.
Under 15	56	10	46	34	18	16	3	1	2	34	20	14	6	9	-3	19	6	13
15 - 24	272	136	136	157	119	38	80	79	1	157	124	33	108	111	-3	137	160	-23
25 - 34	328	240	88	234	125	109	123	112	11	203	215	-12	195	137	58	175	134	41
35 - 44	383	221	162	380	144	236	161	97	64	300	260	40	280	191	89	278	133	145
45 - 54	371	207	164	492	164	328	233	148	85	418	301	117	313	204	109	342	156	186
55 - 64	341	161	180	548	158	390	284	190	94	559	291	268	425	234	191	401	143	258
65 - 74	186	84	102	408	56	352	181	147	34	407	234	173	287	192	95	280	107	173
75 - 84	75	15	60	199	8	191	104	40	64	260	140	120	190	82	108	174	21	153
85 and over	18	1	17	41	3	38	31	7	24	77	52	25	49	23	26	43	8	35
TOTAL	2030	1075	955	2493	795	1698	1200	821	379	2415	1637	778	1853	1183	670	1849	868	981

Chart #2

Comparison of Percentages of Patients Enrolled by Age

for Selected Indiana State Hospitals for FY67 and FY76

Age	Beatty Civil			Central			Evansville			Logansport			Madison			Richmond		
	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.	FY67	FY76	Diff.
Under 15	2.8%	.9%	-1.9%	1.4%	2.3%	0.9%	0.3%	0.1%	-0.2%	1.4%	1.2%	-0.2%	0.3%	.8%	0.5%	1.0%	0.7%	-0.3%
15 - 24	13.4	12.7	-0.7	6.3	15.0	8.7	6.7	9.6	2.9	6.5	7.6	1.1	5.8	9.4	3.6	7.4	18.4	11.0
25 - 34	16.2	22.3	6.1	9.4	15.7	6.3	10.3	13.6	3.3	8.4	13.1	4.7	10.5	11.6	1.1	9.5	15.4	5.9
35 - 44	18.9	20.6	1.7	15.2	18.1	2.9	13.4	11.8	-1.6	12.4	15.9	3.5	15.1	16.1	1.0	15.0	15.3	0.3
45 - 54	18.3	19.3	1.0	19.7	20.6	0.9	19.4	18.0	-1.4	17.3	18.4	1.1	16.9	17.2	0.3	18.5	18.0	-0.5
55 - 64	16.8	15.0	-1.8	22.0	19.9	-2.1	23.7	23.1	-0.6	23.1	17.8	-5.3	22.9	19.8	-3.1	21.7	16.5	-5.2
65 - 74	9.2	7.8	-1.4	16.4	7.0	-9.4	15.1	17.9	2.8	16.9	14.3	-2.6	15.5	16.2	0.7	15.1	12.3	-2.8
75 - 84	3.7	1.4	-2.3	8.0	1.0	-7.0	8.7	4.9	-3.8	10.8	8.6	-2.2	10.3	6.9	-3.4	9.4	2.4	-7.0
85 and over	0.9	.09	-0.8	1.6	0.4	-1.2	2.6	0.9	-1.7	3.2	3.2	0	2.6	1.9	-0.7	2.3	0.9	-1.4
Total Patients Enrolled	2030	1075	955	2493	795	1698	1200	821	379	2415	1637	778	1853	1183	670	1849	868	981

EA FISCAL YEAR

AL R	TOTAL	01 Beatty Civil (2-1951)	02 Beatty MSD (2-1953)	03 Carter (7-1952)	04 Central (11-1840)	05 Evansville (11-1890)	06 Logansport (7-1955)	07 Madison (8-1910)	08 Richmond (8-1890)	09 IMIC	19 Nash	55 Fort Wayne (7-1890)	56 Muncatatuck (12-1920)	58 NICH (7-1961)	59 New Castle (8-1907)	60 EPCC (10-1966)			TOTAL MI
9	12595	1204	339	131	1654	832	1694	1099	1052	—	—	2109	1522	140	795	21			8229
0	11455	1106	307	148	1351	751	1500	1008	946	—	—	2023	1432	149	710	24			7141
1	10704	1081	280	140	1068	707	1441	921	844	—	—	1938	1439	144	684	22			6504
2	9365	810	218	128	969	676	1224	859	669	—	—	1645	1330	137	632	18			5621
3	8573	935	146	106	934	621	1198	786	636	—	—	1399	1261	121	611	19			5181
4	7735	780	123	145	651	617	1081	699	522	—	—	1247	1210	92	557	17			4635
5	7117	666	124	128	655	627	905	719	487			1144	1088	86	491	17			4328
6	6637	598	133	123	555	583	844	641	493			1055	1033	86	470	23			3993
7	6250	499	159	120	575	574	715	636	478			955	956	88	424	21			3777

INDIANA STATE [illegible]
END OF FISCAL YEAR

L.	TOTAL	1-1951 01 Beatty Civil	2-1954 02 Beatty [illegible]	7-1952 03 Carter	11-1840 04 Central	11-1890 05 Evansville	7-1888 06 Logansport	8-1910 07 Madison	9-1890 08 Richmond	09 IHIC *	19 Nash **	7-1890 55 Fort Wayne	12-1920 56 Muncatatuck	7-1961 58 NICH	8-1907 59 New Castle	10-1966 60 EPCC			TOTAL 105
9	9321.				1613	1008	1389	1451	1214			1564	372		910				
0	9548.				1666	1050	1413	1491	1219			1568	374		767				
1	9753.				1707	1113	1442	1508	1221			1563	374		825				
2	10091.				1731	1176	1514	1529	1322			1578	466		865				
3	10402.				1761	1176	1551	1568	1313			1649	502		881				
4	10648.				1760	1179	1557	1605	1344			1699	592		913				
5	10809.				1808	1190	1603	1636	1349			1752	587		915				
6	10922.				1850	1183	1649	1635	1363			1739	596		907				
7	11123.				1857	1159	1656	1659	1366			1919	600		907				
8	11295.				1877	1183	1726	1682	1390			1930	603		905				
9	11932.				1977	1184	1853	1586	1628			1965	832		905				
0	12215.				2090	1199	1939	1576	1629			1966	885		931				
1	12746.				2053	1197	2151	1608	1646			1937	1161		993				
2	12937.				2135	1184	2226	1580	1678			1929	1232		953				
3	12791.				2236	1216	2611	1703	1758			1931	1341		995				
4	12740.				2233	1347	2537	1661	1753			1876	1346		985				
5	12894.				2338	1346	2381	1617	1755			1870	1288		992				
6	12925.				2119	1232	2259	1500	1656			1874	1312		973				
7	12903.				2078	1229	2260	1443	1622			1838	1338		975				
8	12986.				2199	1220	2263	1504	1618			1862	1331		989				
9	13128.				2311	1239	2270	1530	1520			1825	1392		981				
0	13799.				2385	1234	2333	1571	1665	305		1832	1513		961				9493
1	13932.	208			2113	1222	2421	1602	1737	310		1830	1541		948				9613
2	14551.	664			2114	1202	2370	1624	1720	317		1785	1808		947				10011
3	15066.	835		74	2153	1241	2473	1609	1742	207		1826	1967		959				10334
4	15050.	991	74	157	2193	1267	2527	1618	1671	193		1786	1678		895				10691
5	15583.	1331	289	176	2229	1227	2557	1637	1673		27	1816	1701		920				11146
6	15289.	1447	305	88	2153	1236	2380	1630	1651		18	1757	1721		902				10703
7	15332.	1528	343	101	2143	1222	2343	1596	1637		11	1730	1714		934				10754
8	15462.	1577	370	134	2220	1174	2396	1493	1625		23	1734	1772		946				11010
9	15429.	1607	389	174	2208	1153	2378	1449	1586			1722	1809		954				10944
0	15373.	1629	422	185	2180	1099	2293	1429	1561			1831	1802		963				10997
1	15424.	1625	487	161	2221	1103	2206	1430	1585			1871	1767		968				10818
2	15308.	1657	499	171	2150	1021	2245	1344	1533			1899	1784	168	937				10500
3	14920.	1632	509	183	2139	952	2167	1268	1445			1836	1783	167	916				10289
4	14920.	1598	512	171	2194	906	2147	1271	1329			1555	1751	169	917				10188
5	14799.	1566	523	148	2199	903	2134	1261	1405			2001	1699	150	915				10133
6	14887.	1505	494	169	2183	932	2081	1268	1419			2108	1685	155	891				10050
7	14623.	1472	494	170	2113	910	1956	1230	1375			3077	1727	158	870	19			9789
8	13777.	1377	501	137	2008	870	1830	1164	1183			3120	1602	115	820	30			9120

AL R	TOTAL	01 Beatty Civil	02 Beatty MSO	03 Carter	04 Central	05 Evans-ville	06 Logans-port	07 Madison	08 Rich-mond	09 IMIC*	10 Nash**	55 Fort Wayne	56 Muscat-atuck	58 NICH	59 New Castle	60 EPCC
		8-1951	2-1954	7-1952	11-1949	11-1930	7-1938	8-1910	8-16,...			7-1890	12-1920	7-1961	8-1907	10-1966
19	3188.				1557		369					262.				
20	3880.				1583	356	327		299			315				
21	3867.				1541	372	414		368			372				
22	3162.				1503	374	443		421			421				
23	3228.				1512	396	440		428			452				
24	3517.				1478	402	507		435			495				
25	3441.				1543	405	558		438			497.				
26	3667.				1586	394	618		506			563				
27	3753.				1613	477	585		522			556				
28	3865.				1680	510	604		526			545				
29	4126.				1784	577	607		534			622.				
30	4420.				1816	602	621		693			748				
31	4647.				1845	611	772		624			785				
32	4801.				1904	623	771		685			868				
33	5074.				1946	619	831		680			998				
34	5169.				1982	625	850		704			1008				
35	5337.				2070	651	856		724			1036				
36	5096.				1836	651	856		730			1023				
37	5155.				1859	669	868		727			1032				
38	5428.				1850	721	901		779			1096			81	
39	5581.				1818	752.	964		797			1136			114	
40	5679.				1855	761	1001	536	776			1134			116	
41	6005.				1433	798	936	711	814			1199			114	
42	6264.				1362	788	871	1009	827			1223			176	
43	6520.				1516	774	875	1044	831			1252			208	
44	6705.				1536	801	947	1062	845			1288			220	
45	6759.				1542	825	883	1135	853			1290			231	
46	6978.				1561	825	930	1143	864			1350			305	
47	7060.				1528	824	958	1150	875			1388			337	
48	6949.				1412	796	934	1176	874			1409			348.	
49	6997.				1396	802	980	1167.	876			1407			371	
50	7119.				1401	782.	1006	1217	898			1414	30		371	
51	7349.				1455	798	1070	1232	914			1385	80		405	
52	7556.				1529	824	1094	1248	939			1423	103		396	
53	7731.				1532.	831	1159	1266	952.			1475	141		395	
54	7933.				1556.	856	1158	1287	974			1535	169		398	
55	8240.				1596	862.	1196	1325	1045			1516	221		479	
56	8595.				1678	848	1220	1371	1097			1583	232.		606	
57	8818.				1704	824	1275	1395	1082.			1546	304		668	
58	9077.				1546	1026	1303	1433	1147			1568	344		709	

INDIANA STATE MENTAL HOSPITALS
END OF FISCAL YEAR

		2-1951	2-1954	7-1952	11-1848	11-1890	7-1887	8-1910	8-1896			7-1890	12-1920	7-1961	8-1907	10-1966			
FISCAL YEAR	TOTAL	01 Beatty Civil	02 Beatty MSO	03 Carter	04 Central	05 Evansville	06 Logansport	07 Madison	08 Richmond	09 IHIC *	10 Nash **	55 Fort Wayne	56 Muncatatuck	58 NICH	59 New Castle	60 EPCC			
1949	76				76														
1950	80				80														
1951	137				137														
1952	159				159														
1953	163				163														
1954	160				160														
1955	196				196														
1956	235				235														
1957	71				71														
1958	277				277														
1959	303				303														
1960	297				297														
1961	300				300														
1962	298				298														
1963	295				295														
1964	284				284														
1965	262				262														
1966	273				273														
1967	291				291														
1968	291				291														
1969	387				387														
1970	475				475														
1971	477				477														
1972	468				468														
1973	474				474														
1974	482				482														
1975	554				554														
1976	600				600														
1977	614				614														
1978	614				614														
1979	629				629														
1980	1072				1010							62							
1981	1147				1065							82							
1982	1156				1085							71							
1983	1199				1113							86							
1984	1476				1388							88							
1985	1532				1454							78							
1986	1645				1587							58							
1987	1618				1513							105							
1988	2052				1926		292					834							

YEAR	TOTAL	01 Beckley	02 Beckley	03 Carbon	04 Central	05 Everson	06 Logan	07 Madison	08 Richmond	09 Ohio	10 Nash	11 Fort Hayes	12 Mount Clark	13 HIGH	14 New Castle	15 SPOO
1969	16703	1839	345	175	2030	1167	2137	1935	1528	—	—	2509	1896	171	948	23
1970	15827	1755	314	175	1670	1087	2041	1990	1373	—	—	2416	1894	176	910	26
1971	14828	1752	288	185	1376	1021	2045	1589	1237	—	—	2334	1900	172	903	26
1972	13658	1548	227	159	1251	961	1926	1570	1035	—	—	2117	1810	167	863	24
1973	12866	1446	151	151	1029	922	1877	1508	1088	—	—	1936	1716	148	869	25
1974	11790	1366	126	187	923	905	1918	1109	936			1725	1652	144	780	19
1975	11136	1267	128	171	903	916	1659	1236	927	—	—	1527	1551	128	706	17
1976	10330	1075	137	140	795	821	1637	1183	868	—	—	1368	1437	125	721	23
1977	9577	883	163	154	798	749	1517	1204	842	—	—	1327	1265	126	827	22

INDIANA STATE MENTAL HOSPITALS
END OF FISCAL YEAR

YEAR	TOTAL	01 Beatty Hall	02 Beatty Hosp.	03 Carter	04 Central	05 Evansville	06 Logansport	07 Madison	08 Richmond	09 Ohio	10 Nash.	55 Fort Wayne	56 Muncie-Muncie	57 NIGH	58 New Castle	59 EVG
1929																
1930																
1931																
1932																
1933																
1934																
1935																
1936																
1937																
1938																
1939																
1940																
1941																
1942																
1943																
1944																
1945																
1946								1565								
1947								1575								
1948								1604								
1949								1625								
1950	15247	—	—	—	2528	1357	2528	1701	1756	305	—	2259	1798	—	1015	—
1951	15571	212	—	—	2230	1339	2718	1773	1866	310	—	2282	1835	—	1006	—
1952	16203	763	—	—	2205	1311	2580	1781	1855	317	—	2273	2107	—	1011	—
1953	16706	1019	—	77	2248	1340	2673	1729	1882	207	—	2198	2327	—	1006	—
1954	16979	1210	75	172	2309	1357	2789	1815	1813	193	—	2120	2102	—	1024	—
1955	17662	1674	304	191	2413	1447	2877	1860	1805	—	106	2002	1995	—	988	—
1956	17670	1864	318	115	2281	1424	2747	1883	1832	—	83	2046	1984	—	993	—
1957	17602	1586	358	130	2346	1379	2748	1823	1862	—	129	1984	1967	—	990	—
1958	17693	1935	381	170	2370	1311	2850	1782	1830	—	29	1980	2042	—	1013	—
1959	17613	1985	396	207	2402	1258	2679	1826	1811	—	—	1996	2024	—	1029	—
1960	17806	2121	429	201	2375	1184	2552	1856	1824	—	—	2137	2020	—	1037	—
1961	18193	2146	491	184	2480	1203	2550	1884	1967	—	—	2239	1996	—	1053	—
1962	18290	2165	503	186	2434	1192	2635	1806	1858	—	—	2268	2036	171	1042	—
1963	18074	2221	513	196	2410	1159	2582	1661	1823	—	—	2240	2071	178	1025	—
1964	18196	2188	516	206	2449	1095	2528	1745	1938	—	—	2255	2057	190	1035	—
1965	18308	2055	527	181	2505	1137	2475	1805	1962	—	—	2441	2040	175	1068	—
1966	18362	1984	496	190	2488	1183	2448	1921	1854	—	—	2589	2030	182	997	—
1967	18358	2029	486	191	2493	1200	2415	1852	1849	—	—	2562	2093	181	978	19
											—	2514	1943	117	940	22

		2-1951	2-1954	7-1952	11-1949	11-1950	7-1952	8-1910	8-18..			7-1890	12-1920	7-1961	5-1907	10-1968			
AL	TOTAL	01 Beatty Civil	02 Beatty HSO	03 Carter	04 Central	05 Evansville	06 Logansport	07 Madison	08 Richmond	09 IHIC	10 Nash	55 Fort Wayne	56 Muncatatuck	58 NICH	59 New Castle	60 EPCC			TOTAL MI
69	4569	575	40	329	513	496	897	802	685	—	—	102	55	14	21	10			4347
70	3975	506	83	332	423	385	711	723	629	—	—	58	69	11	33	121			3804
71	4036	521	109	367	435	400	652	696	654	—	—	92	64	6	32	8			3842
72	3767	389	161	371	502	364	550	704	568	—	—	64	45	3	32	14			3623
73	3742	471	77	352	388	347	612	659	650	—	—	59	85	2	24	16			3572
74	3783	446	123	393	489	296	614	636	644			59	39	5	13	26			3667
75	3972	452	152	402	579	363	523	675	633			59	45	11	48	30			3809
76	3910	419	154	403	495	327	565	626	690			53	34	27	69	48			3727
77	4196	385	157	421	533	352	541	623	831			81	57	40	139	56			3879

INDIANA STATE MENTAL HOSPITALS

CAL YR	TOTAL	01 Beatty Civil	02 Beatty MED	03 Carter	04 Central	05 Evansville	06 Logansport	07 Madison	08 Richmond	09 IMIC	19 Nash	55 Fort Wayne	56 Muncatatuck	58 NICH	59 New Castle	60 EPCC			TOTAL
		2-1951	2-1954	7-1952	11-1848	11-1890	7-1893	8-1910	8-1[illegible]			7-1890	12-1920	7-1961	8-1907	10-1966			
29	1642	—	—	—	327	234	294	283	250	—	—	136	40	—	78	—			
30	1602	—	—	—	322	283	284	264	187	—	—	97	25	—	140	—			
31	1598	—	—	—	303	289	279	260	188	—	—	168	16	—	155	—			
32	1623	—	—	—	251	295	297	274	169	—	—	150	58	—	129	—			
33	1367	—	—	—	226	196	250	223	197	—	—	162	37	—	76	—			
34	1881	—	—	—	299	315	286	291	280	—	—	211	51	—	148	—			
35	1762	—	—	—	350	300	309	290	246	—	—	128	31	—	114	—			
36	1855	—	—	—	341	329	289	307	279	24	—	134	41	—	109	—			
37	2117	—	—	—	362	358	296	329	282	16	—	308	51	—	115	—			
38	2011	—	—	—	439	365	322	305	300	20	—	135	27	—	98	—			
39	2484	—	—	—	662	362	338	276	316	33	—	220	162	—	115	—			
40	2247	—	—	—	472	387	405	295	369	29	—	105	85	—	100	—			
41	2692	—	—	—	493	390	447	316	385	31	—	295	173	—	162	—			
42	2310	—	—	—	546	358	439	271	350	34	—	119	100	—	93	—			
43	1948	—	—	—	415	157	397	265	351	31	—	151	88	—	96	—			
44	1856	—	—	—	495	0	446	275	300	28	—	91	103	—	103	—			
45	1982	—	—	—	518	72	377	338	312	23	—	120	137	—	85	—			
46	2169	—	—	—	504	312	364	250	347	23	—	153	127	—	89	—			
47	1950	—	—	—	399	282	314	264	351	34	—	111	112	—	83	—			
48	2091	—	—	—	452	301	363	298	353	30	—	124	76	—	94	—			
49	2128	—	—	—	508	245	381	315	367	37	—	81	118	—	76	—			
50	2391	—	—	—	439	283	507	347	389	33	—	97	234	—	62	—			1998
51	2320	37	—	—	347	341	622	306	337	33	—	194	125	—	79	—			1922
52	3007	759	—	—	322	216	462	325	287	64	—	121	389	—	62	—			2435
53	3056	629	—	243	325	224	466	294	261	24	—	113	407	—	70	—			2446
54	3340	516	12	702	325	384	490	333	252	34	—	122	75	—	89	—			3054
55	4399	856	45	732	343	447	914	375	295	0	0	101	334	—	55	—			3809
56	4661	960	85	297	303	456	916	402	317	—	3	122	142	—	56	—			3741
57	4071	961	79	252	379	473	765	456	340	—	114	89	125	—	44	—			3813
58	4286	829	96	341	338	441	838	488	340	—	296	72	160	—	47	—			4007
59	4599	783	119	415	307	510	1078	606	362	—	137	89	56	—	137	—			4317
60	4852	831	130	428	281	493	1212	689	401	—	—	171	111	—	112	—			4464
61	4916	740	151	318	368	520	1192	760	523	—	—	147	125	—	72	—			4579
62	4938	760	130	281	314	494	1371	732	478	—	—	161	155	76	36	—			4560
63	4720	662	106	319	314	512	1239	788	500	—	—	49	134	15	52	—			4450
64	4850	801	134	328	367	437	1191	755	563	—	—	126	82	20	56	—			4566
65	4884	794	149	317	353	470	1062	767	623	—	—	200	92	23	40	—			4529
66	5274	752	144	365	478	477	1175	841	656	—	—	180	136	17	40	—			4104
67	4876	779	118	354	451	500	1043	764	619	—	—	50	169	7	43	20			4607
68	4708	664	63	384	462	542	1034	802	621	—	—	53	29	4	40	10			4552

CAL 88	TOTAL	01 Beatty Civil	02 Beatty MED	03 Carter	04 Central	05 Evans-ville	06 Logans-port	07 Madison	08 Rich-mond	09 IUHC	10 Nash	55 Fort Wayne	56 Muscat-atuck	58 NICH	59 New Castle	60 EPCC
		8-1951	8-1954	7-1952	11-1943	11-1890	7-1908	8-1910	8-[illegible]	-x-		7-1890	12-1920	7-1961	8-1907	10-1966
89																
90																
91																
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13																
14																
15																
16																
17	1333	–	–	–	237	166	280	292	146	–	–	120	–	–	92	–
18	1008	–	–	–	115	168	240	266	98	–	–	73	–	–	48	–
19	1283	–	–	–	363	181	291	272	122	–	–	83	–	–	91	–
20	1110	–	–	–	230	161	194	255	136	–	–	66	–	–	68	–
21	1228	–	–	–	270	163	237	235	153	–	–	70	22	–	78	–
22	1335	–	–	–	318	181	201	268	175	–	–	92	37	–	63	–
23	1353	–	–	–	259	179	202	259	175	–	–	186	32	–	61	–
24	1391	–	–	–	318	175	190	272	221	–	–	137	35	–	43	–
25	1744	–	–	–	382	255	217	282	270		–	159	34	–	175	–
26	1741	–	–	–	418	212	193	306	249	–	–	143	35	–	185	–
27	1553	–	–	–	329	180	259	273	206	–	–	107	34	–	145	–
28	1606	–	–	–	269	271	245	276	219	–	–	116	63	–	142	–

INDIANA STATE MENTAL HOSPITALS

		2-1921	2-1927	7-1958	11-1949	11-1920	7-1963	8-1910	9-1[illegible]			7-1890	12-1920	7-1961	8-1907	10-1966			
[illegible]	TOTAL	01 Beatty Civil	02 Beatty MSD	03 Carter	04 Central	05 Evansville	06 Logansport	07 Madison	08 Richmond	09 IHIC	10 Nash	55 Fort Wayne	56 Muncie-Muncie	56 NICH	57 New Castle	60 EPCC			
969	4746.	653	145	310	680	523	851	705	699.	-	-	94	56	5	16	9			
1970	4133.	511	82	323	677	435	652	548	709	-	-	100	49	1	37	9			
971	4436.	500	96	342	674	431	570	991	702	-	-	131	32	0	19	8			
972	4323.	555	205	395	591	397	495	626	705	-	-	247	92	2	47	16			
973	4047.	563	99	362	567	356	536	623	549	-	-	217	103	10	49	15			
974	4416	488	107	352	574	283	488	965	742	-	-	223	79	7	76	32			
975	4250	526	138	403	579	316	662	479	611	-	-	237	125	26	96	32			
976	4432	604	121	422	596	391	506	627	708	-	-	185	122	28	79	43			
977	4359	551	107	394	640	394	437	555	832.	-	-	122	113	28	99	37			

GML	TOTAL	01 Beatty Civil (2-1951)	02 Beatty MSD (2-1954)	03 Carter (7-1952)	04 Central (11-1943)	05 Evansville (11-1890)	06 Logansport (7-1968)	07 Madison (8-1910)	08 Richmond (8-1890)	09 IUIC	19 Nash	55 Fort Wayne (7-1890)	56 Muncatatuck (12-1920)	58 NICH (7-1961)	59 New Castle (8-1907)	60 EPCC (10-1966)
229																
230																
231																
232																
233																
234																
235																
236	—	—	—	—	165	NA	103	158	127	13	—	15	NA	—	73	—
237	—	—	—	—	179	152	116	168	155	0	—	NA	NA	—	0	—
238	—	—	—	—	201	180	136	163	163	0	—	44	NA	—	42	—
239	1080	—	—	—	196	184	141	175	193	0	—	114	18	—	59	—
240	927	—	—	—	169	238	129	102	205	0	—	28	21	—	35	—
241	1767	—	—	—	207	229	165	161	215	0	—	102	31	—	56	—
242	1154	—	—	—	234	214	170	164	250	0	—	51	25	—	46	—
243	1061	—	—	—	291	176	205	130	187	8	—	49	14	—	1	—
244		—	—	—	272	66	182	114	150	12	—	37	NA	—	83	—
245	330	—	—	—	244	28	171	119	116	14	—	51	15	—	72	—
246	968	—	—	—	243	182	111	140	148	14	—	59	49	—	22	—
247	907	—	—	—	247	156	110	96	156	3	—	111	9	—	39	—
248	1009	—	—	—	191	161	95	128	193	21	—	160	14	—	46	—
249	1386	—	—	—	225	98	194	126	284	47	—	94	200	—	118	—
250	1041	—	—	—	205	165	208	99	176	27	—	52	67	—	42	—
251	1105	10	—	—	244	151	212	112	113	58	—	115	49	—	41	—
252	1418	310	—	—	190	144	270	158	160	38	—	44	82	—	22	—
253	1584	332	—	158	136	111	207	213	139	26	—	153	94	—	35	—
254	2217	273	1	539	156	290	191	145	205	7	—	170	212	—	28	—
255	2844	330	34	644	130	247	417	224	189	2	79	200	284	—	64	—
256	2946	654	57	331	161	357	558	210	174	—	249	49	83	—	38	—
257	3140	834	40	215	201	445	441	348	190	—	206	95	89	—	36	—
258	3100	645	67	305	170	414	483	319	231	—	399	45	17	—	7	—
259	3544	598	82	355	127	457	961	384	250	—	124	54	22	—	130	—
260	3507	510	87	413	138	462	1041	485	204	—	—	18	23	—	96	—
261	3371	563	87	322	143	425	880	519	269	—	—	61	38	—	31	—
262	3740	578	75	268	224	415	1035	621	452	—	—	21	35	0	16	—
263	3793	487	65	291	203	478	1044	713	405	—	—	40	33	1	38	—
264	3782	750	70	304	212	442	1034	540	335	—	—	45	30	1	19	—
265	3828	502	84	316	187	386	928	561	472	—	—	26	33	0	33	—
266	4289	803	77	333	371	323	925	602	649	—	—	46	27	0	23	—
267	3913	523	81	326	328	449	837	644	502	—	—	33	64	1	29	2
268	4477	625	53	384	306	453	910	594	583	—	—	112	100	1	32	8

Chart #4

ACTUAL AVERAGE DAILY POPULATION
BY
INDIANA STATE MENTAL HOSPITALS, 1967-1976

	FY67	FY68	FY69	FY70	FY71	FY72	FY73	FY74	FY75	FY76
MENTAL ILLNESS HOSPITALS										
Beatty-Civil	1,496.9	1,451.5	1,271.7	1,131.0	1,099.0	1,004.6	916.4	884.9	709.5	635.2
Beatty-MSD	494.6	494.1	406.5	310.4	291.0	240.7	195.8	126.7	123.5	133.0
Carter	155.6	157.1	131.5	132.1	152.8	144.4	140.0	141.4	139.1	124.4
Central	2,166.4	2,113.1	1,838.1	1,502.0	1,192.0	1,007.3	857.4	695.6	655.4	609.4
Evansville	923.5	896.4	862.6	803.3	737.8	697.4	659.3	627.3	614.6	608.5
Logansport	2,013.5	1,925.0	1,778.9	1,636.1	1,496.8	1,348.8	1,241.3	1,153.2	987.1	870.6
Madison	1,220.1	1,203.6	1,136.6	1,050.1	961.7	901.6	826.8	761.8	727.0	664.9
Richmond	1,386.9	1,302.8	1,106.8	1,008.2	894.9	742.8	665.2	582.4	518.3	490.3
EPCC	9.3	21.7	22.1	23.7	24.1	20.4	21.1	21.0	22.8	19.6
TOTAL	9,866.8	9,565.3	8,554.8	7,596.9	6,850.1	6,108.0	5,522.9	4,994.3	4,497.2	4,155.9
MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES HOSPITALS										
Fort Wayne	2,129.6	2,142.7	2,169.4	2,114.1	2,023.6	1,827.0	1,571.4	1,327.5	1,211.9	1,098.6
Muscatatuck	1,758.5	1,747.7	1,615.0	1,550.5	1,486.1	1,430.5	1,349.7	1,265.4	1,181.3	1,071.0
Northern Indiana	158.4	140.2	135.1	146.5	148.3	141.6	129.2	110.2	92.7	87.8
New Castle	886.0	848.3	819.7	760.7	696.9	665.0	650.4	595.1	500.6	470.5
TOTAL	4,932.5	4,878.9	4,739.2	4,571.8	4,354.9	4,064.1	3,700.7	3,298.2	2,986.6	2,727.9
ALL HOSPITALS TOTAL	14,799.2	14,444.2	13,293.8	12,168.7	11,205.0	10,172.1	9,224.0	8,292.6	7,483.7	6,883.8

FOR ADMINISTRATIVE
USE ONLY

Division of Planning
and Evaluation
July, 1975

Chart #5

A Comparison of 1975
Forecasted and Actual Average Daily Population
By
Indiana State Mental Hospitals

	1975 Forecast	1975 Actual	Error	Absolute Error
MENTAL ILLNESS HOSPITALS				
Beatty - Civil	740	709.5	-30.5	30.5
Beatty - MSD	122	123.5	1.5	1.5
Carter	145	139.1	- 5.9	5.9
Central	651	655.4	4.4	4.4
Evansville	584	614.6	30.6	30.6
Logansport	967	987.1	20.1	20.1
Madison	675	727.0	52.0	52.0
Richmond	511	518.3	7.3	7.3
EPCC	20	22.8	2.8	2.8
Sub-Total	4,415	4,497.2	82.2	155.1
MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES HOSPITALS				
Fort Wayne	1,174	1,211.9	37.9	37.9
Muscatatuck	1,155	1,181.3	26.3	26.3
Northern Indiana	91	92.7	1.7	1.7
New Castle	550	500.6	-49.4	49.4
Sub-Total	2,970	2,986.6	16.6	115.3
TOTAL	7,385	7,483.7	+98.7	270.4

Error Mean 8
Error % 1.3

Absolute Error Mean 21
Absolute Error % 3.7

Division of
Planning and
Evaluation
July, 1976

Chart #6

A Comparison of 1976
Forecasted and Actual Average Daily Population
By
Indiana State Mental Hospitals

	1976 Forecast	1976 Actual	Error	Absolute Error
MENTAL ILLNESS HOSPITALS				
Beatty - Civil	650	635.2	- 14.8	14.8
Beatty - MSD	130	133.0	+ 3.0	3.0
Carter	140	124.4	- 15.6	15.6
Central	630	609.4	- 20.6	20.6
Evansville	550	608.5	+ 58.5	58.5
Logansport	825	870.6	+ 45.6	45.6
Madison	650	664.9	+ 14.9	14.9
Richmond	450	490.3	+ 40.3	40.3
EPCC	20	19.6	- .4	.4
Sub-Total	4045	4155.9	+110.9	213.7
MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES HOSPITALS				
Fort Wayne	1100	1098.6	- 1.4	1.4
Muscatatuck	1015	1071.0	+ 56.0	56.0
Northern Indiana	90	87.8	- 2.2	2.2
New Castle	450	470.5	+ 20.5	20.5
Sub-Total	2655	2727.9	+ 72.9	80.1
TOTAL	6700	6883.8	+183.8	293.8

Error Mean 14.14
Error % 2.67

Absolute Error Mean 22.6
Absolute Error % 4.27

FOR ADMINISTRATIVE
USE ONLY

Division of Planning
and Evaluation
September, 1976

Chart #7

Forecast of Indiana State Mental Hospital
Average Daily Population
By Using Cohort Survival Method FY76 to FY81

Length of Stay	June 30, 1971 Patients Enrolled	June 30, 1976 Patients Enrolled	Survival Ratio	Projected June 30, 1980 Enrollment
0 under 5	5,075	3,999	.2085	4,066
5 years under 10	2,398	1,362	.2684	1,073
10 years under 15	1,606	1,260	.5254	716
15 years under 20	1,478	953	.5934	748
20 years under 25	1,167	894	.6049	576
25 years under 30	877	624	.5347	478
30 years under 35	822	445	.5074	317
35 years under 40	572	380	.4308	192
40 years under 45	341	211	.3689	140
45 years under 50	223	117	.3431	72
50 years and over	209	85	.1968	40
	14,828	10,330		8,418

Chart #8

Actual and Forecasted Patients Enrolled
By Using Component Method for
Indiana State Mental Hospitals FY67 to FY81

ACTUAL

Fiscal Year	Enrollment July 1	Admissions	Deaths	Discharges	Enrollment June 30	Average Daily Population	Difference
FY 67	18,354	4,876	958	3,914	18,358	14,799	3,559
FY 68	18,358	4,708	928	4,477	17,661	14,444	3,217
FY 69	17,661	4,569	781	4,746	16,703	13,294	3,409
FY 70	16,703	3,975	718	4,133	15,827	12,169	3,658
FY 71	15,827	4,036	599	4,436	14,828	11,205	3,623
FY 72	14,828	3,767	564	4,373	13,658	10,172	3,486
FY 73	13,658	3,742	485	4,049	12,866	9,224	3,642
FY 74	12,866	3,783	444	4,416	11,789	8,293	3,496
FY 75	11,789	3,972	376	4,250	11,135	7,484	3,651
FY 76	11,135	3,914	289	4,429	10,331	6,884	3,447
							M=3,520

FORECAST

FY 77	10,331	3,900	284	4,250	9,697
FY 78	9,697	3,900	250	4,250	9,097
FY 79	9,097	3,900	220	4,250	8,527
FY 80	8,527	3,900	193	4,250	7,984
FY 81	7,984	3,900	170	4,250	7,464

Chart #9

ACTUAL AND FORECASTED AVERAGE DAILY POPULATION
For
INDIANA STATE MENTAL HOSPITALS
FY67 to FY81

	Mental Retardation and Other Developmental Disabilities			Mental Illness		
Date	Average Daily Population	MR/DD Clients Enrolled	Family Care Patients	Average Daily Population	Outpatient Terminations	Family Care Patients
ACTUAL						
FY67	4,933	1,500 est.	285	9,867	7,627	343
FY68	4,879	1,700 est.	351	9,565	10,789	532
FY69	4,739	2,000 est.	427	8,555	11,893	532
FY70	4,572	2,657 est.	510	7,597	13,780	715
FY71	4,355	3,250 est.	492	6,850	15,816	702
FY72	4,064	3,927	564	6,108	18,030	784
FY73	3,700	4,595	634	5,523	19,328	864
FY74	3,298	5,971	598	4,994	22,249	916
FY75	2,987	7,256	574	4,497	22,973 est.	886
FY76	2,728	6,948	561	4,156	23,946 est.	902
FORECAST						
FY77	(2,540)	8,000	600	(3,537)	25,500	1,000
FY78	(2,353)	8,500	625	(3,130)	26,500	1,075
FY79	(2,167)	9,000	650	(2,724)	27,500	1,150
FY80	(1,980)	9,500	700	(2,341)	28,500	1,200
FY81	(1,792)	10,000	750	(1,959)	29,500	1,250

Chart #10

ACTUAL AND FORECASTED AVERAGE DAILY POPULATION
BY
INDIANA STATE MENTAL HOSPITALS, 1976-81

Hospital	FY, 1976 Actual	FY, 1977 Forecast	FY, 1978 Forecast	FY, 1979 Forecast	FY, 1980 Forecast	FY, 1981 Forecast
MENTAL ILLNESS HOSPITALS						
Beatty - Civil	635.2	575	550	525	525	525
Beatty - MSD	133.0	110	100	100	100	100
Carter	124.4	130	130	130	130	130
Central	609.4	550	525	525	525	500
Evansville	608.5	550	525	500	450	400
Logansport	870.6	775	725	675	625	575
Madison	664.9	625	575	525	475	450
Richmond	490.3	500	475	450	425	400
EPCC	19.6	20	20	20	20	20
Sub-Total	4,155.9	3,835	3,625	3,450	3,275	3,100
MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES HOSPITALS						
Fort Wayne	1,098.6	1,000	950	900	850	800
Muscatatuck	1,071.0	1,000	950	900	850	800
Northern Indiana	87.8	90	90	90	90	90
New Castle	470.5	450	425	400	375	350
Sub-Total	2,727.9	2,540	2,415	2,290	2,165	2,040
ALL HOSPITALS						
TOTAL	6,883.8	6,375	6,040	5,740	5,440	5,140

Introduction

On the most basic level, program evaluation must proceed from an understanding of the philosophical underpinnings of a program. Until the philosophy of a given plan is clearly understood, the success of programs instituted to effect that plan cannot be assessed. Programs must, after all, be evaluated according to how well they implement the philosophy from which they have evolved.

In mental health, the dominant theme in program planning over the past decade has been deinstitutionalization of services. Numerous programs have been designated and instituted in an effort to meet the demands and goals of the deinstitutionalization movement; but relatively little has been written about the subtleties of the philosophy underlying the movement. Consequently, many program plans have proceeded in something akin to a conceptual vacuum. Needless to say, it has been difficult to evaluate the effects of these programs in any fundamental sense.

This paper represents an attempt to articulate the philosophy of the deinstitutionalization movement in mental health by presenting a conceptualization of the issues and problems which have arisen. It shows that failure to get a broad philosophical perspective on the movement has resulted in difficulties in program implementation. Finally, it concludes that an appreciation of the conceptual dimensions of the movement is the sine qua non of effective program planning in mental health.

Toward a Definition of Deinstitutionalization

The term, deinstitutionalization, though widely used, is rarely defined. In practice, it is variously used to refer to a broad scope of patient-connected events, ranging from carefully planned local efforts at community care, to mass releases of patients into communities, as State hospitals have been "phased out" or closed. That disparities in usage of the term exist results from the fact that deinstitutionalization is an extremely complex phenomenon. Each individual involved with deinstitutionalization tends to know best -- or perhaps exclusively -- only that portion of the movement with which he is personally involved. Accordingly, it is well to begin any discussion of deinstitutionalization with a definition of the term.

Deinstitutionalization may be defined as a process involving two elements -- (1) the eschewal, shunning or avoidance of traditional institutional settings, primarily State hospitals, for the care of the mentally ill; and (2) the concurrent expansion of community-based services for the treatment of these individuals.

This definition, by focusing on physical properties -- i.e., the locations where mental health services are provided -- describes the operational aspects of deinstitutionalization. Postulating such a definition may be viewed as a first step in establishing a conceptual framework for understanding the deinstitutionalization movement. The definition, by itself, affords enough shared understanding to remind mental health practioners that deinstitutionalization is not a unilinear phenomenon encompassing only the release of patients from mental hospitals. Rather, it is a more general term which involves, in addition to hospital releases, an exchange in the locations of mental health care.

In addition, this definition also provides a base from which the more subtle implications of the deinstitutionalization movement may be explored. It suggests that there is more to deinstitutionalization than its locational aspects and implies that deinstitutionalization is best understood as a movement possessing dynamic qualities.

Elements of Deinstitutionalization

At least three separate, but interrelated, basic elements in the deinstitutionalization movement may be isolated: (1) deinstitutionalization as a process; (2) deinstitutionalization as a philosophy; and (3) deinstitutionalization as a fact.

Deinstitutionalization as a process -- Deinstitutionalization, rather than being an isolated event, is a dynamic and continuing series of adjustments and accommodations. All components of the mental health service delivery system are involved. Physically, the process may be set in motion in the mental hospital, through the release of those already hospitalized. Or it may begin in the community through the prevention of hospitalization by provision of community-based alternative services. Wherever it starts, the process, once begun, continues. The idea of a "continuum of care" that is so closely associated with the community mental health movement is a reflection of the dynamic quality of deinstitutionalization. Ideally, at least, with deinstitutionalization the patient is permitted to move freely from facility to facility, or even in and out of the service delivery system. His current needs will determine his utilization patterns.

Deinstitutionalization as a philosophy -- When deinstitutionalization is viewed as a process, its intellectual foundation begins to become appare

The deinstitutionalization movement is the expression of a philosophy current in American thought. This philosophy places strong civil libertarian emphasis on the rights of patients and on the modification of environment as the primary avenue to humane patient care (1).

The philosophy of deinstitutionalization proceeds from at least three fundamental assumptions concerning mental health care. First, there is an assumption that community mental health is a good thing -- that community-based mental health care is preferable to institutionalized care for most, if not all, mental patients. Community care is perceived as the more therapeutic alternative, and it represents the treatment of choice in most cases of mental illness.

A second underlying assumption is that functions performed by the mental hospital can be equally -if not better - performed by community-based facilities. The idea of deinstitutionalization, in other words, implies that the community is capable of providing, outside of institutional settings, those patient services which are available within the hospital.

Finally, deinstitutionalization is based upon an assumption that communities not only can, but also are willing to, assume responsibility and leadership in the care of the mentally ill.

These three philosophical assumptions, taken together, permit an understanding of the charge of deinstitutionalization. The operational definition proposed earlier, with its emphasis on the locational aspects of patient care, may now be supplemented with a goal definition. The goal of deinstitutionalization is lofty and is rooted in the philosophy of the movement. Deinstitutionalization has assumed no less a task than that of "humanizing" mental health care - a task which would reverse the dehumanizing influences of institutionalizing the mentally ill.

Deinstitutionalization as a fact -- Deinstitutionalization, then, is both a process and a philosophy. But it is something more as well: it is also a fact. The movement toward community-based care in this country has a reality dimension that cannot be overlooked. Although this paper is primarily concerned with the conceptual aspects of deinstitutionalization, brief mention may be made of some statistics which provide evidence for deinstitutionalization as a fact.

In 1955, about half of the psychiatric patient care episodes in the Nation occurred in State mental hospitals; (2) but in 1973 the percentage was less than one-fifth (Table 1). On the other hand, outpatient

(Table 1 about here)

services accounted for only 23% of psychiatric patient care episodes in 1955 but for as many as two-thirds of all episodes in 1973. Federally funded community mental health centers, which did not even exist prior to the passage of the Community Mental Health Centers Act of 1963, accounted for 23% of psychiatric patient care episodes in 1973 (2).

There has also been a dramatic decrease in the size of State hospital resident populations. The number of resident patients in State mental hospitals peaked at over half-a-million in 1955. It has been decreasing ever since. In 1975, the number of State mental hsopital residents was only about 193,000 (3,4).

Functions of the Mental Hospital

Acknowledgment and consideration of these properties of deinstitutionalization -- process, philosophy and fact -- permit a framework for better understanding of the issues in the deinstitutionalization movement. Were deinstitutionalization merely an event with locational referents -- were it concerned only with the exchange of settings for patient care --

many of the problems associated with the movement would not have arisen. The community would merely have replaced the hospital as the locus of care, and resultant problems would have been of a logistical nature, easily negotiated and resolved.

In fact, however, deinstitutionalization has, since its inception, confronted obstacles every step of the way. There are numerous issues associated with deinstitutionalization of the mentally ill, and experience of the past decade has demonstrated that these issues have been extremely difficult to resolve. It is not the intention of this paper to rehash the issues in deinstitutionalization; this has been done often and with great skill in the literature. A recent publication (5) proposes a taxonomy of issues in deinstitutionalization and provides brief summaries and appropriate bibliographic citations. The taxonomy of issues provided in Figure 1 is based on that work.

(Figure 1 about here)

In the preceding discussion of deinstitutionalization as a philosophy, it was noted that one underlying assumption of the movement is the premise that functions served by the mental hospital can be equally, if not better, performed in community-based facilities. What, exactly, are these functions? A review of the literature suggests that the range of functions realized by mental hospitals is surprisingly complex and is far more extensive than might be supposed. While treatment, asylum and custody are the functions most often associated with institutional care (6), the literature reveals a whole series of additional functions that are less readily observed (7,8,9,10,11,12). It is safe to say that some of these functions were not originally intended but have evolved naturally as the system of institutional care has grown in this country.

An attempt to isolate some of the functions of the mental hospital as identified in the literature yields 19 separate items (5). This listing, shown in Figure 2, is limited to those functions explicitly stated in the

(Figure 2 about here)

literature. Were it to be expanded by the inclusion of such functions as are also implicit in the literature, it would be even longer. The listing includes the widely acknowledged function of providing long-term care for chronically disturbed individuals. It also includes some other functions that are perhaps less often perceived or acknowledged -- like rendering relief to the patient's family and providing a sort of hiding place outside the community for some of its less attractive members.

An important observation emerges when the lising of mental hospital functions presented in Figure 2 is compared with the issues in desinstitutionalization classified earlier in Figure 1. The issues in deinstitutionalization fall into two major groupings vis-a-vis mental hospital functions. Either: (a) the issue has at least one referent among the functions listed, or (b) the issue has come into being as a latent function — an unanticipated consequence — of the deinstitutionalization movement itself. With respect to the former grouping, it is apparent from a review of the literature (5), that efforts to reduce the stature of, or eliminate, mental hospitals have placed disproportionate emphasis on the function of treatment and have too often neglected to stress the necessity for alternatives to the custodial and other functions of mental hospitals. It is inevitable that any movement which so ignores the institutional makeup of society will encounter severe opposition.

With respect to the latter grouping of issues — those which emerge

as products of the movement itself — it is apparent that the deinstitutionalization effort in process has not been viewed by its champions with sufficient detachment to permit program planners to recognize problems and introduce necessary modifications. Deinstitutionalization has left in its wake a series of dysfunctional elements which result directly from rapid, and sometimes heedless, implementation of the movement. (13)

Efforts to replace mental hospitals with community-based facilities have too often taken place in a sort of functional vacuum. They have too frequently failed to stress the necessity for providing alternatives to the range of mental hospital functions and focused only on the function of providing treatment. Although mental health practitioners may be reluctant to acknowledge that some of the other functions have been part of the mental health care system, denial alone will not make them disappear.

However, the tide appears to be turning. Early literature on deinstitutionalization, which reflected the mood underlying program planning in the 1960's, largely ignored or discounted the extra-treatment functions of mental hospitals. Recognition of the functions of asylum and custody, and of the other functions listed in Figure 2, has become more and more prevalent in the literature of the mid-1970's. Thus, Slovenko and Luby (14) write:

> The medical model terminology has been misleading. When we use the term "hospital," we naturally think of treatment. Hospitalization without treatment is an absurdity. If, however, we understand by the term "hospitalization" nothing more nor less than asylum (as the mental hospital at one time was called), a place of refuge, there is no connotation of medical treatment but rather one of treatment in the broad sense as meaning "handling of" or "how we treat one another."

Conclusions

It is frequently forgotten that deinstitutionalization, for all its positive thrust, is basically a protest movement. Deinstitutionalization is best understood as the obverse of institutionalization. It follows, therefore, that comprehension of the sociology of mental institutions is prerequisite to understanding the nature of deinstitutionalization. A basic assumption underlying the philosophy of the deinstitutionalization movement -- that the community can and will provide alternatives for the range of functions performed by the mental hospital -- has been shown, through functional analysis, to be, at best, fuzzily conceived. Functional alternatives for the mental hospital cannot be provided nor effected by the community until the totality of functions is, first, understood; second, acknowledged; and, finally, dealt with in the planning process.

After more than a decade of deinstitutionalization efforts, it is now necessary to take a fresh look at the deinstitutionalization movement. The issues which have emerged need to be faced squarely, so that the movement can pursue its goal of counteracting the dehumanizing effects of hospitalization. In summary, mental hospitals can be effectively superseded only when: (1) there is an objective and thorough understanding of the functions which they serve in American life; (2) consensus is reached as to which of these functions should be continued or discontinued, or which new functions should be added; (3) effective alternatives are established in community settings for the accepted functions; and (4) sufficient time is allowed for the systematic and orderly implementation of new programs and transfer of functions.

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'able 1. Number and percent distribution of patient care episodes by type of facility and modality, mental health facilities, United States 1973

Type of Facility	All Services	Inpt.	2/ Outpt.	Day 1/ Treatment	All Services	Inpt.	2/ Outpt.	Day 1/ Treatment	All Services	Inpt.	2/ Outpt.	Day 1/ Treatment
	Number of episodes (in 000's)				Percent Distribution by Type of Facility				Percent Distribution by Modality			
ll Facilities	5,475	1,718	3,571	186	100.0	100.0	100.0	100.0	100.0	31.4	65.2	3.4
Non-Federal Psychiatric Hospitals	1,205	775	403	27	22.0	45.1	11.3	14.5	100.0	64.3	33.5	2.2
State and County Hospitals	1,014	652	339	23	18.5	38.0	9.5	12.4	100.0	64.3	33.4	2.3
Private Hospitals	191	123	64	4	3.5	7.1	1.8	2.1	100.0	64.4	33.5	2.1
A Psychiatric Services	362	208	144	10	6.6	12.1	4.0	5.4	100.0	57.4	39.8	2.8
Neuropsychiatric Hospitals	152	91	60	1	2.8	5.3	1.7	0.5	100.0	59.9	39.5	0.6
General Hospitals	210	117	84	9	3.8	6.8	2.3	4.9	100.0	55.7	40.0	4.3
on-Federal General Hospitals	999	475	489	35	18.3	27.6	13.7	18.8	100.0	47.6	48.9	3.5
Public Hospitals	398	142	238	18	7.3	8.2	6.7	9.7	100.0	35.7	59.8	4.5
Nonpublic Hospitals	601	333	251	17	11.0	19.4	7.0	9.1	100.0	55.4	41.8	2.8
esidential Treatment Centers for Emotionally Disturbed Children	53	29	22	2	1.0	1.7	0.6	1.1	100.0	54.7	41.5	3.8
ederally Funded CMHC's	1,256	192	983	81	22.9	11.2	27.5	43.5	100.0	15.3	78.3	6.4
)ther Multiservice Mental Health Fac.	165	39	120	6	3.0	2.3	3.4	3.2	100.0	23.7	72.7	3.6
'ree-Standing Outpatient Clinics	1,428	-	1,407	21	26.1	-	39.4	11.3	100.0	-	98.5	1.5
Public	693	-	682	11	12.7	-	19.1	5.9	100.0	-	98.4	1.6
Nonpublic	735	-	725	10	13.4	-	20.3	5.4	100.0	-	98.6	1.4
'ree-Standing Day/Night Facilities	7	-	3	4	0.1	-	0.1	2.2	100.0	-	42.8	57.2

1/ Excludes partial care other than day treatment services

2/ Does not include outpatient care provided in private psychiatric office practice

Source: Taube, C.A., and Redick, R. W. Provisional data on patient care episodes in mental health facilities, 1973. Mental Health Statistical Note No. 127. Rockville, Md.: National Institute of Mental Health, February 1976.

Figure I

A Taxonomy of Issues in Deinstitutionalization *

I. Issues related to the selection of patients for community care

A. Chronically ill patients
B. Patients inadequately prepared for life in the community
C. Disadvantaged and minority groups

II. Issues related to the treatment course of patients in the community

A. Inadequate range of treatment services
B. Fragmentation and lack of coordination in community treatment services
C. Inaccessibility of treatment services
D. Questionable quality of care in community services

III. Issues related to the quality of life of patients in the community

A. Inadequate community support systems
B. Residential facilities and living arrangements

IV. Issues related to the greater community

A. Community resistance and opposition to mentally ill individuals
B. Effects on communities to which patients are released
C. Ecological impacts on economy of hospital community and on hospital staff
D. Effects on patient's family

V. Issues related to the training and re-training of staff for community work

VI. Financial and fiscal issues

VII. Legal and quasi-legal issues

VIII. Informational issues and accountability

A. Necessity for evaluation studies
B. Difficulties in locating and following patients in the community
C. Inadequacy of existing follow-up studies

IX. Additional issues resulting from the process of deinstitutionalization itself

A. Timing: precipitate implementation of new programs
B. Inadequate attention to patients' desires
C. Problems related to providing adequate services in hospitals during phase-out
D. Failure to establish liaison between hospitals and community-based facilities
E. Role-blurring
F. Disenchantment with the deinstitutionalization movement: resistance to further change

* Adapted from Bachrach LL: Deinstitutionalization: an analytical review and sociological perspective. Mental Health Statistics, Series D, No.4. Rockville, Md.: National Institute of Mental Health, 1976.

Figure II

Functions of Mental Hospitals *

Providing long-term care for chronically disturbed individuals

Providing for the patient respite from mounting pressures

Removing the patient from his regular environment and whatever pathological influence that environment may have

Protecting the patient from exploitation by others

Providing a residential environment for the mentally ill

Providing constant and continuous monitoring and review of the patient's course of illness

Providing a social structure within which the role of the mentally disturbed individual is clearly defined

Providing the mentally ill individual with an alternative to due process of law

Providing the patient with a place to which he may escape from the greater societ

Providing a means by which society can segregate some of its deviants

Relieving the patient's family and community from disruptive social interaction

Protecting society from the acts of dangerous individuals

Supplying an ostensibly relatively inexpensive form of patient care

Providing an economic base and employment for a community or a portion of a community

Providing for numbers of employed persons job security and other job perquisites

Providing a tax base for local communities

Providing for mental health professionals a "siphon(ing) off (of) the least affluent and least attractive mentally disturbed" (8)

Creating an "illusion that all local mental health needs are being met, thus eliminating the need for...local planning and spending for mental health care" (8)

Providing a place for research on mental illness and training of mental health professionals

* Adapted from Bachrach LL: Deinstitutionalization: an analytical review and sociological perspective. Mental Health Statistics, Series D, No. 4. Rockville, Md.: National Institute of Mental Health, 1976.

DEINSTITUTIONALIZATION: A CONCEPTUAL FRAMEWORK

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A STAFF DEVELOPMENT PROGRAM IN INDIANA STATE MENTAL HOSPITALS BY 1980

Introduction

The purpose of this paper is to develop a staff development program for the twelve state mental hospitals operated by the Indiana Department of Mental Health for the year 1980. After a brief discussion of the Department of Mental Health as it exists in 1975, a forecast will be [illegible] development recommendations.

State Hospital System, 1975

The Indiana General Assembly appropriated 177.4 million dollars for operating and capital expenditures to the Indiana Department of Mental Health for the 1973-75 biennium. Approximately 145.3 million dollars are for the operation and capital expansion of twelve state hospitals. Thus, almost 80% of the Department's budget is used to support state hospitals. The remaining 20% is for the support of a variety of community programs including community mental health centers and facilities for the mentally retarded and other developmentally disabled.

There are twelve state hospitals located at various sites in Indiana with a combined April, 1975, patient present population of 7,245 individuals.

Approximately 7,400 full-time employees and 370 part-time employees, plus consultant staff were employed in the state hospitals in March, 1975. The majority of staff members are paraprofessional

attendants plus institutional workers with a professional staff composed of a variety of clinical disciplines and administrators.

There is some type of staff development program within each hospital with a minimum overall coordination from the Central Office of the Department of Mental Health. Staff development positions and funds have not received financial support from the General Assembly. However, a staff development program is currently being formulated between the Department of Mental Health and the School of Public and Environmental Affairs of Indiana University. Since a staff development program is being developed for the current delivery system, the investigat~~ion~~or will develop recommendations for a forecasted future system.

Forecast

The patient present population in the Indiana state mental hospitals has been declining at a steady rate since 1967. (See chart in Appendix.) The June, 1966, census was 14,887 patients as compared with a June, 1974, census of 7,736. This represents a reduction of 7,151 patients. The national data for state and county mental hospitals plus public institutions serving the mentally retarded show a similar decline in census.

Assumptions for the State Hospital Delivery System

1. The General Assembly will <u>not</u> decide to close a state hospital by 1980. All twelve hospitals will be operational, however the patient population in the larger hospitals will be reduced.

2. The incidence and prevalence of mental illness, mental retardation and other developmental disabilities, alcoholism and drug abuse will continue at the current rates.

3. There will be a constant proportion of the State's population at high risk (the poor and socially disadvantaged, unemployed, and others) which produce state hospital patients at a high rate.

4. There will be increased acceptance of the mentally ill person, the mentally retarded and developmentally handicapped individual, the alcoholic, and the drug abuser in his or her home community when proper treatment and support services are available.

5. There will be sufficient funds appropriated by the Federal, State and local legislative bodies to construct and operate the planned 32 community mental health centers, community residential facilities and halfway houses for the mentally ill, day and residential facilities for the mentally retarded and developmentally disabled, plus outpatient and inpatient facilities for those persons with addiction problems.

6. Mandatory special education in the public schools will reduce the number of emotionally disturbed school age children and adolescents entering the state hospital system. A similar effect would occur for mentally retarded children and adolescents.

7. There will be a gradual increase in the number of current state hospital patients placed on Family Care status.

8. There will be a sizeable expansion of the number of halfway houses, small group homes, and other community residential services for

the mentally ill, plus the mentally retarded and developmentally handicapped patient. The full impact of such a development will not be felt until 1978.

9. The mental health service delivery system, both state hospital and community components, will become increasingly more effective and efficient which will result in a reduced need for long-term state hospital care and treatment, plus the average length of stay in a state hospital will be reduced.

10. A national health insurance program will have a significant impact in lowering the number of patients served in state mental hospitals. This insurance program with mental health benefits will become law by June, 1976. The full impact of this program will be felt by state hospitals by January, 1978.

A forecast was made in another study by the investigator using the above national data and assumptions plus other quantitative data and forecasting techniques. The resultant forecast was a further decline in state hospital population and a 1980 census figure of 5,200 patients. (See Appendix.) While this forecast may not be entirely accurate, such a decline in population will cause problems within the organization (Indiana Department of Mental Health) and community organizations. A well organized staff development program could assist the Indiana Department of Mental Health to help solve the problem ramifications of such a forecasted decline.

Ramifications of the Forecast and Recommendations

1. There will be a good chance that the General Assembly may appropriate less funds for Personnel Services than they did for the 1974-75 Fiscal Year. Additional justification may be needed as to why state hospitals will require the same or more staff while the number of patients continues to decline.

Recommendation

1A. The Department should do manpower study on the number and qualifications of staff needed to provide a high level of treatment services in the state hospitals by 1980. Included in this study is to establish standards and appropriate evaluation techniques to determine services needed and manpower requirements to deliver these services. The study should also include a discussion of the effect of the Wyatt-Stickney Standards if they are required as a result of a "right to treatment" suit against the State of Indiana.

1B. A full-time adult educator should be assigned to the Central Office of the Indiana Department of Mental Health. This person would be responsible for organizing a staff development program for the twelve state hospitals as well as spending a major portion of his or her time in working with the community agencies (board, staff and clients) which are a part of the mental health delivery system.

1C. An adult educator should be on the staff of each state hospital to develop and implement staff development programs for the hospital as well as community agencies who relate to the state hospital.

1D. A survey should be made of the employees of the Indiana Department of Mental Health to determine their staff development needs at this point in time (April, 1975). This information would provide baseline data for a staff development program to meet the needs of the mental health delivery system in 1980.

1E. There should be a continuous staff development program organized to meet the changing needs of the state hospitals. The staff development program should include such things as pre-service and inservice training programs, self-study, planned work experiences, visits to other state hospitals and community agencies (including out-of-state trips) horizontal transfers within the state hospital system and the Central Office, exchange employee program within state government, and community agencies, participation in state and national professional organizations, attendance at state, regional, and national conferences, encouragement of applied research and the publication of the findings by an in-house publication or national periodicals, and other such adult learning experiences to enable the employee to be more valuable to the state hospital.

1F. The adult educator at the Central Office level and at the state hospital should recognize the Department of Mental Health as a social organization as well as a unit of state government. There is a very definite informal structure that exists with the formal table of organization. There is a large number of employees with many years of service who know each other. The adult educator will need to be able to work with the informal system, especially if the organization is threatened with lay-offs or closing of a hospital. The Central Office needs to recognize that, while he may have authority, he will need to

earn the power to implement his programs within a state hospital managed often by a medical doctor with considerable independence. Each hospital has its own social system and relationships to community agencies. The reference groups of many of the staff may be more concerned with in-hospital programs rather than hospital-community activities. However, the reference group of newer staff members may be oriented toward community programs without an understanding of the possible contributions of a state hospital. A staff development program should address both situations. As state hospitals become smaller there may occur an administrative change in a state hospital. Some state hospitals have already moved from departmental to an unit system. More personnel will be working with community agencies and some departments, such as nursing, dietary, maintenance, and others will lose employees.

1G. As state hospitals become smaller they will become more multi-purpose and serve mentally ill, mentally retarded and developmentally disabled, plus the drug abuser and alcoholic. A staff development program will need to upgrade the clinical skills to serve patients who have traditionally not been served in a particular state hospital. State hospitals that have formerly served mainly the mentally ill will have additional mentally retarded patients. State hospitals that have specialized in serving them mentally retarded may need to serve the mentally ill patient.

1H. More attention should be given to public education and information by the adult educator. The consumer of the services and the general public should have a better understanding of mental health (as opposed to mental illness) and should know what to expect if they seek professional services for an emotional problem.