Social Consequences of Policy Toward Mental Illness

Indiscriminate shifts from hospital to community treatment may incur high social costs.

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Oliver Wendell Holmes observed in 1861 that medicine "is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density" (*1*). Medicine and health are now major issues in political discourse, public policy decisions, and resource allocation; but substantive scientific and medical data frequently get short shrift in the decision-making process. Pilot programs and experiments have usually not been undertaken before full-scale programs are put into effect. Consequently, massive health and welfare programs are mounted with inadequate consideration of potential iatrogenic consequences or other contraindications. Only now, on a very cautious and small scale, are clearly experimental studies of new social policy being undertaken (*2*).

The political–public-policy process is such that, once a program of respectable size and political prescription is mounted, it is extremely difficult to change its course even if there is mounting evidence that its cost or its harmful effects far exceed its benefits. When the policies involve ideological issues, they may rather quickly pass through a process of "social validation" (*3*) and acquire a life of their own, divorced from empirical validation or refutation.

The mental health movement experienced its initial impetus following World War II, but its growth accelerated markedly in the early 1960's as part of a widespread recrudescence of concern for social and institutional reconstruction and distributive justice. The term "mental health," which had at first served primarily as a euphemism for "mental illness," now expanded to aggregate all behavior ranging from the everyday thoughts and feelings and inner life of everyman to the extreme psychosocial disturbances of the florid psychoses. If any boundaries and conceptual precision ever existed for the term mental illness, it was now lost. With the elevation of the mental health movement to a position of national prominence, reflected in congressional acts and presidential speeches, public policy issues emerge with considerable import for society at large rather than only for a limited spectrum of afflicted individuals. Specifically, the issue of community mental health (treatment of the mentally ill at home and in the community, in contrast to the traditional mental hospital treatment) brings with it a host of potential trade-offs. Community treatment and the planned complete phasing out of the public mental hospital have become official policy of federal, state, and local government, with enthusiastic sanction from professional and citizens' organizations. The policy stance was stated in the report of the Joint Commission on Mental Illness and Health (*4*):

> The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all service to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them day hospitals, night hospitals, aftercare clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and expatient groups.

Along with the shift to community treatment and maintenance, concepts of prevention adapted from traditional public health principles have emerged, directed toward intervention in and modification of conditions assumed to cause or be conducive to mental illness (*5*).

The growth of the mental health movement and its component disciplines, as well as the general reorientation to community-based treatment, has come under a continuous stream of criticism and comment from an extremely diverse range of critics, whose views are often at polar extremes (*6–10*). The major public policy decisions, however, have tended to ignore substantive issues and developments in biological psychiatry and the behavioral sciences and have been predominantly determined by short-range political expediency and the pressures of social reform. A compelling body of systematic evidence now exists to suggest not only that the actual cost-benefits of community treatment (using cost in its broadest social sense) are far less than its advocates proclaim, but that the consequences of indiscriminate community treatment may often have profound iatrogenic effects; in short, we may be producing more psychological and social disturbance than we correct (*11–15*).

Terms and Assumptions

Given the global and imprecise usage of the terms "mental illness" and "mental health," some narrowing of focus is necessary. To a great extent, the lumping of all behavior together reflects a guiding assumption of many mental health professionals, and advocates of community mental health programs in particular, that all behavior exists on a continuum; that differences between the problems of living, on the one hand, and the psychoses, on the other, are quantitative, not qualitative (*7, 16*). It is further believed that intervention in the early stages of development of a problem can prevent disability and that treatment will reduce morbidity and disability (*5*). In an excellent discussion of this assumption, Mechanic (*8*) has called attention to the conjectural nature of these assumptions and to the growing body of evidence to the contrary. It increasingly appears that the psychoses, especially the chronic psychoses, are qualitatively different from other forms of psychological disorder. In a now classic study of the rates of mental illness in Massachusetts over the last century, Goldhammer and Marshall (*17*) found that there was no evidence to support the belief that psychosis was increasing in modern society, and no systematic data have yet appeared to alter their conclusion. Despite diagnostic, theoretical, and cultural differences, the rates of hospitalized psychoses remain quite similar among the developed Western societies, nor do they appear to vary much over time (*8*). Although the practices of military psychiatry have varied over time, rates of hospitalized psychoses in the armed forces

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show considerable consistency between World War I and World War II; no essential differences in psychosis rates emerge under extreme combat conditions or bombing attacks (*18*), nor do rates of psychoses increase in civilian populations exposed to bombing or other stresses (*8*). An impressive body of evidence over time and across cultures regarding rates of psychoses, coupled with the extensive evidence on concordance and consanguinity in schizophrenia and manic-depressive psychosis (*19, 20*), testifies against the idea of a simple behavioral continuum of psychopathology and does not support the belief that treatment, intervention, and policy formulations can be meaningfully addressed in a nonspecific, global manner.

As used in this discussion, "mental illness" refers to the major psychoses, and no attempt will be made to discuss in detail the issues of community treatment for other conditions. A considerable literature demonstrates that psychotics can be treated in the community, can be discharged from hospital after very brief hospitalization, and can be maintained in the community, as evidenced by lower rates of readmission (*13, 14, 21, 22*). Such studies, however, are essentially "program effectiveness" studies which demonstrate that it is possible to accomplish the stated program or to implement a particular policy. Our concern here is with "program benefits"—the costs and benefits attendant upon the implemented program. Although the factors involved in the decisions to hospitalize, the determination of suitability for discharge, and subsequent success in avoidance of readmission are staggering and of profound importance to a complete review of the current mental health scene, they will not be discussed here. Rather, existing studies of the effects of community treatment on family, siblings, and offspring, as well as the psychotic patient, will be examined and then related to current theories of development and social functioning. Unfortunately, and despite the importance of the questions, such studies remain quite scarce.

Since the turn to community treatment represents a retreat from the apparent failures of confinement in the public mental institutions, some discussion of the historical rise and fall of these institutions is essential to an understanding of the factors involved on the current scene.

The Mental Hospital

"Throughout the greater part of human history the role of the medical man in the care and treatment of the mentally ill has been a minor one. Only in recent decades has the medical approach assumed a dominant position in this field. . . . The story of the mentally ill falls largely within the penumbra of social welfare development . . ." (*23*). Consequently, and as has been amply documented, conceptions of mental illness and the treatment afforded those labeled mentally ill have reflected prevailing religious, moral, and social philosophies, a state of affairs characteristic of psychiatry and the entire mental health field from their inception up to and including the present time. Although advances in medical and scientific knowledge have occurred and have been incorporated into practice, the major trends in the field continue to be dominated by social philosophy, moral suasion, and belief under the guise of medicine. This is most glaringly apparent in the consideration of the role of the mental hospital itself as a treatment modality.

While 18th-century European reforms brought drastic changes in the humanitarian aspects of confinement of the mentally ill, medical advances were meager. In the New World, changes from the European pattern began to evolve and were incorporated into major social policies concerning poverty, welfare, and prisons during the Jacksonian era. During this period of time, overall concern for social change and social progress, free of European tradition and tailored to the new society, gave rise to a wave of optimism about the perfectability of man and his social order. This optimism extended to mental illness: the psychiatrists of the time and their lay supporters insisted that insanity was curable, in fact more curable than most other ailments (*24*). They believed that the causes of insanity were to be found in the social order and environment, and cure was to be brought about by a corrective environment which would remedy the deficiencies of the society. The programs of the "asylum," which came to be known as "moral treatment," were widely and extravagantly proclaimed; legislatures were petitioned to create state-supported institutions for the insane, and by 1860, 28 of the 33 states had done so. By 1870, however, these institutions had suffered a dramatic decline from reform to custodial establishments, and "both the reality of institutional care and the rhetoric of psychiatrists made clear that the optimism of reformers had been unfounded, that the expectation of eradicating insanity from the new world had been illusory" (*24*, p. 265). Now psychiatrists began to reexamine their earlier optimism and decided that insanity was becoming more of an incurable disease, that earlier statistics were erroneous, hospitalization was inadequate to accomplish the desired ends, and mild cases were best treated at home. The state-supported mental institutions deteriorated into understaffed, overcrowded places of last resort. They were not again to occupy a prominent role in public policy until after World War II, although private institutions for the mentally ill continued to develop, often providing models of the care, attention, staffing ratios, and treatment possible in an institutional setting.

Thus, while public mental institutions rose and fell on the basis of exaggerated claims, erroneous beliefs, utopian social philosophy, and fallacious rhetoric, private hospitals continued to develop, and they flourish to this day. It is essential to recognize that the detrimental effects of institutionalization that are currently expounded are not necessarily a function of institutionalization per se; they appear to exist in interaction with the quality of the institution and the type of patient (specific illness and its stage). Institutionalization, even "total institutionalization" (*25*), is not a unique characteristic of mental institutions but rather is a possible and probable consequence in any setting characterized by neglect and depersonalization (*13*). The current policy position of a large segment of the mental health professions, the National Institute of Mental Health, and the lay lobby organizations, that institutionalization is detrimental and the public institutions should be phased out over the shortest span of time possible, is based upon the logical fallacy that since bad hospitals are bad for patients, any hospitalization is bad for patients and should be avoided entirely or made as short as possible (*10*). Reinforcement for this position is provided by the most limited type of cost accounting and administrative statistics, from which it is fallaciously concluded that economies will be realized by such policies. Thus it is made to appear that humanitarian ends can be achieved at lower cost, an outcome that has obvious popular appeal. That this policy will eventually lead to the need to rediscover the public mental institution has already been noted (*12, 15, 26*), since there unfortunately remain large numbers of chronic psychotics who are unable to exist outside of an institutional setting.

Stress, Environment, and Asylum

Current theories of individual psychosocial functioning and dysfunction place considerable emphasis upon environmental and social stress and interpersonal, intrafamily processes. Basic individual biology is often completely ignored or alluded to grudgingly; learning processes are considered primary in etiology. Thus, from psychoanalysis through operant condi-

tioning theories, although the terminology is vastly different, the learning process is invoked as the basis for specific maladaptive behavior, thoughts, and feelings of those to whom mental illness is ascribed. As has been indicated above, this emphasis upon the community, the environment, and the social system as primary sources of stress is certainly not new. But earlier the mental institution was seen as a place of asylum, where free from the stresses, strains, and corruptions of the social order the patient could be retrained; where the past evils would be unlearned and a corrective, totally new learning environment provided (*23, 24, 27*). Now, however, the patient is seen as best treated within the setting that is presumed to have induced or contributed to his illness. (It is an interesting commentary of the times that the term "asylum" and its literal meaning of protection and safety are no longer used with reference to mental illness, but usually only appear in the context of politics.) The apparent paradox has been commented upon in detail by Kubie (*10*). Concomitantly with their ascribed etiologic role, these same family contacts and social environments are now seen as maximally therapeutic, and the patient is to be maintained in the community and home rather than in the hospital.

The paradox arises because health policy is formulated largely on the basis of beliefs and attitudes which, at their best, represent uncritical clinical judgments but certainly not systematic explorations of specific contexts of treatment for specific types of conditions. The continuing tendency is to deal with global aggregates of patients and treatments under vague rubrics such as "mental health" or "mental illness," while ignoring the growing body of literature indicating the absolute imperative for reliable differential diagnosis leading to specific therapies and therapeutic modalities (*28*). Probably the most striking example of such differentiation is that between schizophrenia and affective (depressive) psychosis, which leads to the use of quite different pharmacologic agents and therapeutic regimens (*29*). At this point, however, the conceptual inconsistency of treating the patient in the very environment that is seen as the cause of his problems needs further amplification. Taking as the point of reference the heavy emphasis upon learning as the basis of treatment modalities, with the attendant public policy decisions in favor of community treatment, we may compare these choices with available data on the psychotic patient in the family and community settings. In this fashion, the broader effects of current policies may be examined within the context of total social costs.

Social Learning and Developmental Psychopathology

With hospitalization to be avoided or kept as short as possible, many mental patients who in the past would have been removed from the family situation now remain at home; many children who in the past would have had little exposure to a psychotic parent, being reared by one parent or by parent surrogates, are now exposed to a psychotic parent or parents in varying states of pharmacologically controlled remission. What effects may be produced or exacerbated by such circumstances, where learning and imitation are seen as of major developmental importance? The development of the child as a social organism has been approached from a variety of perspectives, including multifaceted and multidisciplinary formulations. In all of them early experience is seen as leaving permanent residues in the individual; they all view socialization as socially purposive to some degree; and in most some version of adaptation is seen which integrates individual development and societal goals (*30*). Central to these theories is the role of the parent or parent surrogate in providing models, explicit and implicit, to the developing organism. This is not to be taken as necessarily minimizing biological determinants of behavior. Even the most biologically based theories acknowledge the role of environmental factors in shaping specific behaviors and evoking extreme stress responses in those genetically prone. Diathesis-stress models (*19, 20, 31*) in particular acknowledge the environmental role while detailing specific genetic involvement in mental illness. What then are the effects where the behavioral models are distorted or defective or when the child is caught up in the emotional turbulence of major parental mental disorder?

Despite the importance of the question, there have been few controlled, long-term studies of children of psychotic parents. Enough data have been collected, however, to lead current investigators to regard such children as a high-risk group for the development of some form of psychiatric disorder at some point in their lives. Although data indicate both genetic and environmental factors, assignment of differential risk is not yet possible. Consistently, the studies of the children of psychotic parents show higher rates than the general population not only of schizophrenia and manic-depressive psychosis but of other types of psychological and behavioral disturbances (*32–36*). Thus, Anthony's research finds that in a group of such children about 15 percent will themselves develop a psychosis, approximately 40 percent will become juvenile delinquents or engage in some form of antisocial behavior, and the rest will be essentially normal, including a subgroup of about 10 percent who are actually superior, creative people. There is obviously no simple relationship; the work of Mednick and Schulsinger (*32*), Anthony (*34–36*), and Reisby (*37*) indicates complex interactions between length of time with parent, type of parental illness, sex of parent, and so on. In this regard it is important that consideration not be limited to the behavior (symptoms) of the parent but be extended to the broader network of relationships and communications within which the child's thought processes, coping mechanisms, affective response patterns, linguistic abilities, and normative standards evolve. The disturbances in these patterns in the setting of the psychotic parent are current foci of intense study and give rise to what Anthony (*36*) has recently described as "the contagious subculture of psychosis." The new treatment policies have led "to an increase in the incidence of ambulatory and remitted psychosis in the general population. Since the relapse rate has remained relatively constant throughout this time, families are being exposed, more than ever before, to the initial stages of psychotic episodes . . . but the potential detriment to the family members resulting from the presence of a psychotic person in their midst has not received the careful scientific scrutiny it deserves. As the traffic between home and hospital multiplies, a point may be reached when the mental health needs of the community as a whole conflict with the mental health needs of individual patients" (*34*, p. 312).

It would appear that this point may have been reached and that its implications need to be incorporated into new policy formulations, resource allocation, and psychiatric practice as well as into extensive further research. We still do not know the relative effects (strengths and weaknesses) upon the offspring's later behavior and performance of being removed from the care of the psychotic parent or being exposed to that parent, as a function of type of parental illness, sex of the parent, length and intensity of exposure, and the critical periods of maximum developmental effect on specific psychological functions. Supposed benefits for the patient alone can no longer suffice as determinants of policy when the data so strongly indicate potential iatrogenic effects on others. These points are even more strongly reinforced by the few studies which actually compare treatment at home and in the community with treatment in the hospital when the dependent variables are not only improvement of the patient but also family and social costs.

Community and Home versus Hospital Treatment

The mental health literature contains an impressive number of studies of the effects of treatment, the focus of which has been primarily on the patients themselves. Given the highly social nature of mental health theorizing, assumptions, and policies, it is surprising that such a small segment of the research deals with the social cost and impact of treatment and practice. Conceptually the need to abandon the individual patient model in favor of a more extensive, complicated (and costly) systems model is not at all new. The issues, summaries of research, and their policy implications have been excellently presented by Mechanic (*8, 9*), Kahn (*12*), Wing and Brown (*13*), and Kramer (*38*).

A study by Pasamanick *et al.* (*21*) lends itself to examination of the issues we have been raising. The study was a comparison of the effects of hospitalization and nonhospitalization (home treatment) on several groups of schizophrenic patients observed for 6 to 30 months. The authors concluded that the study demonstrated the feasibility of caring for schizophrenics at home and that the methods and procedures used were effective in preventing hospitalization. Direct data for assessing our concerns of social cost and social policy are not provided, but inferences may be drawn from some of their data, particularly those relating to psychiatric and social functioning after 6, 18, and 24 months. In all the groups, most of the improvement occurred during the first 6 months; there was only minor improvement, if any, thereafter. The rates of improvement during these first 6 months did not differ appreciably among the groups. Thus one form (locus) of treatment appears to have had no advantage over the other, at least so far as the individual patient is concerned.

The disruption to family and community of the home-care groups was highest in the beginning, with disturbing and disturbed behavior occurring frequently but decreasing significantly during the first 6 months. Of course the families and communities of those patients who were hospitalized were relieved of the burden, whereas the families of home-treated patients continued to experience their difficulties. It can be concluded that there is considerable social cost in keeping the patient on home treatment, at least during the initial, acute illness phase, with no clear-cut therapeutic advantage to the patient. A 5-year follow-up of these same patients revealed no differences in social or psychological functioning between those who had been treated in the hospital originally and those treated in the community (*39*).

Another study (*40*) was more directly concerned with family and community costs as well as patient outcomes in a 5-year follow-up of 339 schizophrenic patients. A considerable proportion of the relatives of these patients stated that the patients' illness was harmful to their own health, had produced disturbances in the children, and was accompanied by considerable financial difficulties. In another follow-up study (*41*) patients and their families were studied 2 years after hospital-based or community-based treatment; the authors report that hospital-based treatment was more effective in reducing anxiety and distress among patients' relatives, and that the community care families were much more likely to be having a variety of problems 2 years later. Other investigators report similar findings (*13, 42, 43*).

From all the studies available two essential points emerge: from the standpoint of the individual patient, community or home treatment is not necessarily superior either in its short-term or its long-term effects; and secondly, when the scope of investigation includes the family and relatives, "the burden on relatives and the community was rarely negligible, and in some cases it was intolerable" (*13*, p. 192). Thus, when considerations of psychiatric morbidity are extended to the effects on relatives and the community, it becomes clear that current treatment policies maintain or promote psychological disturbance which more realistic approaches could minimize and oftimes prevent.

Neither maintenance in the community during treatment nor return to the community after brief hospitalization can any longer be viewed as meaningful indicators of either effectiveness of treatment or social functioning. Follow-up studies of psychotic patients returned to community tend to reveal distressingly high percentages of marginal or poor adjustment and of unemployment, and for many a subsequent need to return to hospital and remain there (*13, 43, 44*). The existence of many ex-patients outside the hospital mirrors that of those within, but in an environment which, at best, must be accommodated to maintain them, at a social and economic cost rarely calculated or studied. The pharmacological agents that account for a good deal of the effectiveness of the community care policy are in themselves a mixed blessing, for often there are iatrogenic neurological sequelae as a consequence of the long-term and often haphazard, massive dosage used to prevent rehospitalization (*45*).

One other aspect of the community policy for psychotic patients needs comment: its relation to procreation by the mentally ill. There are two questions here: the ability of mentally ill parents, particularly mothers, to provide adequate care to their children, and the probability of increased fertility rates of those who now reside in the community rather than in an institution. As to the first point, mentally ill parents can and do provide care which ranges from essentially sound to the other extreme of terrible neglect and trauma. The essential aspects of these potential effects were discussed earlier. As to the second, it has been observed that since the shift to a community focus rather than an institutional one there has been a marked increase in birth rates among the severely mentally ill, for both legitimate and illegitimate births (*46*). Thousands of schizophrenics and others who could not bear children while in custodial settings are now in the community with biological capability of reproduction (*12*). As recently described by Rosenthal (*19*), the pattern of natural selection in man has changed markedly over time and this is apparently true for the mentally ill as for man in general. The increased reproduction of those who previously were in custodial settings increases their inputs into the potential gene pool. Given the striking research consensus on the presence of genetic as well as environmental factors in predisposition to and development of disorder in such high-risk populations, Rosenthal suggests that "future generations may include many more mentally ill persons, and those predisposed to mental illness, than exist today" (*19*, p. 11).

Summary and Conclusions

That reform movements often create more problems than they solve has been noted (*47*), and the task of each succeeding generation is to correct the excesses of the last; the issues and problems are not unique to mental illness. 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 long overdue for the field of mental health. With regard to the psychoses and schizophrenia and the issues of treatment in community instead of institutional settings, "it is . . . important to point out that the evaluation of different types of social policy and social structure can only be properly undertaken when there are adequate measures of morbidity in patients and relatives. Administrative indices such as length of stay, staff-patient ratios, re-admission rate or cost-per-patient week are valueless in themselves" (*13*, p. 11). As Mechanic (*8*) has cautioned, it is these indices that are most subject to administrative manipula-

tion, yet it is these same administrative indices that are continually presented to legislative bodies as the basis for policy formulation and resource allocation.

It can be argued that the present state of affairs is related to the encumbering of psychiatry with more responsibility and greater expectations than reality would permit accomplishment of; to the rapid creation of new mental health professions and subspecialties, which continue to fight for their place in the sun; and to the continued reliance upon belief, conjecture, and the political process to deal with problems for which hard data either already exist or can be readily obtained. Somewhere along the line, a problem as old as man, that of mental illness, was absorbed into the pursuit of global mental health. As Dubos (*48*) has written, any significant social change will be reflected in the health of a society, and behavior as an intrinsic aspect of overall health is also a reflection of social change, social forces, and social policies. But there has been a consistent failure to distinguish between objectives explicitly related to mental health and objectives that affect mental health (*49*). The care and treatment of the mentally ill, although providing the impetus for the social reform movement, receded into the background, increasingly impervious to the research and data it had generated. Although the objectives and goals were those of health, the language and idiom increasingly were those of politics rather than science or medicine. Consequently, the impetus of the mental health movement to obtain resources for purposes explicitly related to mental illness became diffused once again to broader social goals and welfare philosophies which may affect the chimera, mental health. The range and sequence of treatment modalities initially seen as offering great hope and promise—smaller, better-staffed hospitals, halfway houses, sheltered workshops, emergency protective resources, *and* community treatment centers—never were implemented, as political enthusiasm, fed by inflated rhetoric, moved to community treatment, eradication of social ills, and the elimination of the publicly supported mental institution. It is highly conjectural that the severely mentally ill have had their lot that much improved in the process.

Both data and theory already exist to permit a systematic reevaluation of mental health policy so as to minimize long-term undesirable effects while focusing on the specific needs of specific types of illness.

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