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Deinstitutionalization: The Illusion of Disillusion

Michael McCubbin

Université de Montréal

This article reevaluates the recent tendency to attribute economic causes — cost and fiscal factors — to deinstitutionalization and its subsequent "treatment in the community" mental health system. Economic determinist explanations are shown to be inadequate; instead, the primary impetus behind deinstitutionalization is seen to be the conception of a more humanistic "community care" alternative. How deinstitutionalization was transformed into a mere shadow of that model is explained by analyzing the mediation of social institutions. It is proposed that disillusionment and policy paralysis be replaced with a teleological approach to planning: a long-term strategic plan based on goals and emphasizing the policy environment.

> Disillusion can become itself an illusion
> If we rest in it.
>
> (T.S. Eliot, 1958, *The Cocktail Party*, Act 2, p. 138)

Over the last decade the mental health policy literature has unveiled a myriad of political, structural and economic factors that contributed to asylum depopulation and helped to shape the subsequent "treatment in the community" mental health system. The failure to establish the originally envisioned "community care" system in an era of financial restraint has led to a tendency to revise, in hindsight, the perceived impetus behind deinstitutionalization. This impetus is now often seen as economic (cost and fiscal factors), rather than humanitarian (changed attitudes toward the mentally ill and new paradigms placing the problem of mental illness in a broader psy-

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chosocial context). This article suggests that it would be a misreading of even that literature which emphasizes cost and fiscal arguments to conclude with economic determinist explanations. Instead, I suggest that much of the "economic" impetus for deinstitutionalization was shaped by humanitarian factors, and that the failure to establish community care is not evidence of the weakness of the humanitarian explanation but rather of the inertia of the system due to the power and interests of various social institutions.

Aside from their explanatory weaknesses, economic determinist arguments can create cynicism, disillusion and policy paralysis. Events understood as the consequence of economic "forces" rather than of decisions made by human agents, given their interests and the social structures within which they operate, seem beyond the reach of policy. This article will conclude with the observation that policy efficacy is possible — i.e., that real progress toward a humanitarian, tolerant, psychosocial community care system is attainable — *if* policy directs itself to the structure of the mental health policy system itself. The powers of government bureaucracies, issue advocacy groups, pharmaceutical companies, and the psychiatric profession, mediate and distort well-intentioned incremental reforms. It is time for reformers to pay concerted attention to the nature of the system *itself* as a prerequisite to achieving reform *within* the system.

Background

For at least twenty years the mental health policy literature has focused on deinstitutionalization as the major system "event" in the second half of this century. Reforms begun during the 1960s raised the hopes of many that a new "biopsychosocial" paradigm of "mental illness" and its treatment was on the horizon, ushering in more humane forms of treatment that regarded the patient as a whole person with various psychosocial needs that require attention, not primarily or necessarily to cure the "illness," but to facilitate the patient's normalized participation within society, thereby reducing the harmful impact of symptoms. The paradigm envisaged an array of support services, including counselling, advocacy, housing, transportation, social and home care skills training, education, income, and a variety of therapy alternatives; the core of the system would be the patients' needs or choices, aided by advocacy and means for participation in the system, and integrated for the patient through programs such as case management and community centres. There was broad acceptance of this model of community care, pursuant to an ecological model of mental health, at least in terms of public pronouncements of major mental health system actors (Bloche and Cournos, 1990; Hollingsworth, 1992; see Tyhurst, Chalke, Lawson, McNeel, Roberts et al., 1963).

By the 1980s, at the end of the era of precipitous declines in asylum populations, analysts began displaying a disquietude as to the impacts of the deinstitutionalization movement for patients and society (e.g., Beck and Parry, 1992; Boudreau, 1986; Callahan, 1984; Isaac and Armat, 1990; Rachlin, 1989; Toews and Barnes, 1986). Deinstitutionalization was increasingly perceived as a partial or complete failure: in this regard the attempt at social engineering undertaken in the mental health field suffered from disillusion similar to that following other major social policy initiatives such as the "war on poverty" (Lesemann, 1986).

Some of the major ideological components of the reform movement had become distorted: mental health services, even when labelled "community care," were rather "treatment in the community" (Goodwin, 1989) — where intervention consisted almost entirely of biomedical psychiatric treatment provided to out-patients or short-term general hospital patients (Bachrach, 1981).[1] A tacit assumption of the mental health system was that there were already adequate family supports for outpatients to draw on, or that physically locating them "in the community," with minimal personal entitlements to medical treatment and income, somehow substituted for the wide range of psychosocial and economic supports envisioned under the full community care model.

Today, after a brief flowering of diversity within psychiatry, that profession has become almost exclusively a technical specialty of mainstream biomedicine. The medical model orientation is stronger than ever before in psychiatric practice (Breggin, 1991; Cohen and Cohen, 1986; MacLennan, 1989). As a consequence, the team or case management models of professional intervention under the community care model have become hierarchical structures controlled by psychiatrists or psychiatric conceptions (Hollingsworth, 1992; Prior, 1991; Regan, 1987). Active patient participation has become symbolic or nonexistent.

Economic Explanations of Deinstitutionalization

Recently, there has been a growing tendency to downplay the positive forces behind deinstitutionalization noted by earlier writers including Brown (1985), Foley (1975), and Rochefort (1984): the search for more humane interventions, combined with greater public tolerance for relatively harmless deviances. In parallel, economic forces have been stressed. Correlations between asylum population declines and changes in funding and entitlement programs have suggested to some analysts that "the most powerful and imme-

[1]Although data on non-medical support are sparse and dated, this is the case even for clients included in community support programs (Kiesler and Sibulkin, 1987, pp. 196–199).

diate impetus was fiscal" (Bloche and Cournos, 1990, p. 393). The obvious strength of this impetus, combined with other factors such as declines in public spending, the appearance of chronic homelessness of many ex-patients, and the failure to establish community care programs, has created the cynical impression that cold economic facts, rather than the laudable objectives of social reform, were behind the process. For example, Dain (1989) concluded:

> The speed with which the vast system of state mental hospitals, despite all the latter's financial resources and political connections, could be virtually denuded of patients bespeaks more of a desire of state governments to save money and a lack of public support for hospitals than a great faith in alternatives . . . . (p. 7)

However, identification of causes as economic raises the question of why economic incentives or constraints should have changed. The remainder of this section suggests that economic factors often mask more fundamental changes in mental health policy and attitudes.

Cost Arguments

The attitude of cynicism regarding the forces behind deinstitutionalization is noted by Hollingsworth: ". . . many critics of mental health policy suggest that the continuing interest in minimizing mental hospital care is as much an expression of cost control as a concern for patient welfare" (1992, p. 909). Johnson (1990) provides a typical example of this suggestion:

> Depopulation of the state mental hospitals did indeed take place, but not really because more enlightened public attitudes toward the mentally ill made it possible to relocate them to more suitable settings within the community — it took place because the states couldn't afford to provide lifetime care for a huge and growing chronic caseload inside enormous, crumbling hospitals built in the nineteenth century, which proved to be extremely expensive to run at twentieth-century prices. (p. xxii)

While asylum populations were increasing for several decades up to the 1950s (Mechanic and Rochefort, 1990), this fact alone cannot explain subsequent depopulation due to the costs of the system. Indeed, the "cost" argument is explicitly or implicitly based on non-economic factors; e.g., "There have been frequent suggestions that deinstitutionalization was financially inspired, that one state after another turned people out of mental hospitals because it was too costly to provide the level of care *mandated by courts*" (Hollingsworth, 1992, pp. 907–908, italics added).

The influence of legal action in improving asylum conditions, and thereby increasing costs, has been somewhat underrated and forgotten. While only an extremely small number of patients were able to obtain legal help, deci-

sions were precedent-setting and had "class action" impacts. One of the first major impacts during the 1950s was upon hygiene standards. As a result, overcrowded, unsanitary institutions suddenly were faced with the need for major expansion, renovation, or replacement. Subsequently, as a result of further legal and political action, the asylums had to increasingly dispense with the use of physical constraints, requiring more costly alternatives: more staff, fewer patients, redesigned environments. By the early 1960s, "right to treatment" cases were being filed seeking to require asylums to not only maintain residents in adequate physical conditions, but also provide "psychiatric care" (Wald and Friedman, 1978). In retrospect, these legal outcomes have to be regarded as a significant gain for the psychiatric profession, while imposing increased costs on public and private asylums (Bassuk and Gerson, 1978; Brown, 1984).

Insofar as increased costs per patient were a result of increased pressure from advocates, families and the public for both more humane maintenance and psychiatric care, identification of cost as the primary instigating factor for deinstitutionalization would be misleading. Rather than an economic argument, therefore, this becomes a social and political argument based on society's changing expectations concerning appropriate care, and on the increased power of patients and advocates in gaining access to legal and political levers.

The cost–benefit ratio of asylum care did increase during the deinstitutionalization era, due to legal reforms requiring higher standards of care. Alternatives for less severely impaired patients became more attractive, once rudimentary "treatment in the community" approaches were set up. Setting up a new system for a new type of market requires major capital investments: not only in terms of staff and facilities, but also in terms of the intellectual capital expended in conceptualizing and planning the new approaches. It is reasonable to suppose that the timing of the move to asylum alternatives was influenced by "lumpy" capital formation and economies of scale; i.e., the equipment, facilities and staff required for a "treatment-in-community" model (and much more so for the "community care" model), are not infinitely divisible into small fractions. Jones (1988) suggests that a community mental health centre needs to be staffed for service to a population of 100,000 to 200,000. It is likely that factors favouring the creation of a new mental health market came together at a time when a "watershed" was reached at which there were sufficient potential new customers to implement the market. Again, it would be far too narrow a perspective to view this as an asylum cost issue. Rather, the preparation of a society undergoing a paradigm change met the opportunity created by the improving economic feasibility of care in the community.

It is possible that perceptions of costs and benefits of asylum care changed due to changed ability to gather and calculate information (arguably an eco-

nomic factor), or due to changes in tastes of the public and the decision-makers (a non-economic factor). The former might be manifest in an explanation of deinstitutionalization as the result of science: e.g., the ever more refined tools of health policy analysis finally revealed that it was "inefficient" from a public policy standpoint to retain so large a proportion of those considered mentally ill in institutions. This would provide the only reasonable support, among the cost-related issues discussed above, for emphasizing the cost of asylums as the major causal factor behind deinstitutionalization. However, the more influential critiques of asylum efficacy were not applied policy analysis and evaluation technique but instead fundamental challenges to the paradigms underlining our understanding of mental illness and its place in society.

Fiscal Arguments

The fiscal cause argument implies that an inexorable movement out of the asylums was begun due to the inability of governments to bear the costs of the asylum system (Scull, 1979). It is difficult to see how *capacity* to bear costs can be considered as a major depopulation factor. Deinstitutionalization began during the 1950s and 1960s, when North America was enjoying major economic boom years; this was the period of the most rapid growth in the welfare state. New money was massively injected into new health, welfare and income security programs (Interprovincial Conference, 1980).

While inspection of a particular asylum or sub-national political jurisdiction might reveal a public finance explanation for the nonsustainability of asylums, such fiscal difficulties can be attributed to the circumstances facing specific states or provinces over a limited period of time. In such analysis, historians need to avoid uncritically adopting the fiscal rhetoric of politicians. For example, in the landmark *Wyatt v. Stickney* case [1971] (cited in Wald and Friedman, 1978), the Alabama government pleaded that it could not afford the ordered asylum improvements — pleas the judge did not accept after hearing evidence that Alabama had appropriated that year substantial sums to finance a beauty pageant and a sports hall of fame. A crucial but little known threat to the affordability argument is that civil libertarians and their lawyers made a strategic decision to first attack asylums on the basis of standards rather than on involuntary commitment or broad treatment efficacy considerations, believing that this step would hold early promise in forcing system change (Wald and Friedman, 1978).

In general, during the 1960s and early 1970s sub-national governments discharged or transferred patients in response to incentives, associated with alternatives, rather than in response to affordability considerations. In both Canada and the United States new policies provided new forms of funding —

subsequently cut or severely restrained during the "supply side" era epitomized by the Reagan presidency — for more decentralized forms of care, to individuals (e.g., Medicare), or simply to other institutions (Bloche and Cournos, 1990; Rochefort and Portz, 1993). Indeed, it appears that the most sudden drops in asylum populations are attributable to "transinstitutionalization": transfer of patients to specialized facilities for elderly, children, veterans, criminals, and hospital chronic care beds (Morrissey, Goldman, and Klerman, 1985; Simmons, 1990).

From the perspective of a particular state or province, cost might be the important factor, but from the perspective of an historical analysis of mutations in the North American mental health care system, attention has to be directed to the reasons for the federal government funding changes. In this regard, as discussed above, the capacity of the national governments to maintain funding for asylums does not appear to have been impaired over the period when deinstitutionalization gathered steam. However, since the 1970s, governments have had increased fiscal difficulties due to lower increases in national product growth and tax revenue and increasing costs in various sectors. This reality points to fiscal problems as not a major cause of deinstitutionalization, but as a barrier to subsequent reinstitutionalization — should we decide the experiment was a failure — and as a barrier to realizing or maintaining the community care alternatives originally envisaged.

Mediation of Social Institutions

Society is not made up of homogeneous marbles where planning can be based on the laws of motion of any small set. Rather, individuals associate with each other within complex networks of interacting and overlapping groups, institutions, and rules. Caring and generous people face a variety of incentives and constraints such that their acts can appear selfish, inhumane and alienating, as illustrated by the prisoner's dilemma (Watzlawick, 1976). This complicates the tasks of predicting the course and evaluating the success of a particular mental health intervention.

The Kennedy administration's *Community Mental Health Centers Act* epitomizes the failed or stalled attempt to achieve a revolution in mental health care by direct government intervention. Many problems in implementing community mental health care ideals have been enumerated in the literature (Clark and Dorwart, 1992; Ehrenreich and Ehrenreich, 1971; Nassi, 1978; Regan, 1987). A major limitation of the plan in the United States was that it was up to the various states to take advantage of the cost-sharing proposal: some chose not to adopt the model, and many others watered it down to their own liking (Castel, Castel, and Lovell, 1982; Hastings, 1986). In both cases the intervention, conscious or unconscious, of various social institu-

tions resulted in the failure or distortion of the initiative. The prevailing narrative regarding this failure does not pay sufficient attention to these social structure elements, placing most emphasis on government failure to provide financing for the non-medical psychosocial components of the model (e.g., Boudreau, 1987; Hollingsworth, 1992; Jones, 1988). The implication of this failure is that a lack of will on the part of the public — society in general — sabotaged the plans (Scull, 1990).

While the continued resolve of the general public to spend money on a new and innovative program was clearly insufficient, we must be careful to distinguish between the inherent sentiments of individuals and how those sentiments are influenced, gathered, weighted and transmitted within the political process. At each step of this process barriers and diversions were erected due to the power of groups and institutions whose interests, or perceptions of interests, diverged from that of the idealized homogeneous "voter" (Marmor and Gill, 1989). Following is a partial list of such unforeseen difficulties.

Government bureaucracies. State and province responsibility for mental health care was usually assigned to a health or hospitals department, even though the philosophy underlying community mental health centres (CMHCs) required a new interdepartmental approach in their planning and implementation (which would greatly reduce the health department role and control of resources). These departments and their political representatives were able to frame issues and guide planning in such a way as to turn CMHCs into hospital wards or attached clinics, run by medical practitioners and hospital administrators (Castel et al., 1982; MacLennan, 1989; Regan, 1987).

Pharmaceutical companies. The power of pharmaceutical companies to influence political decisions by lobbying, and psychiatric practice through selective support for medical school programs, conferences and journals, and various gifts to practitioners, is clearly immense. That it has been effective is demonstrable by the amounts spent and by the fact that psychiatry now relies almost exclusively for its practice on psychoactive drugs (Breggin, 1991). Very little research aims to show how promotion directly influences prescriber behaviour; Orlowski and Wateska (1992) studied a sample of physicians receiving expenses-paid trips to resorts for drug symposia and showed that not only did prescription of the promoted drugs rise markedly, but the prescription of the alternate drugs did not fall. Lauzon (1993) found that the major drug companies spend twice as much on promotion than on research. Only within the last few years have some steps been taken by the medical/psychiatric professions to reduce conflicts of interest created by drug company gifts and support of professional/educational activities (Rosner, 1992). However, in recent decades the power of the pharmaceutical industry, particularly

as it has evolved into an oligopolistic multinational set of cartels, has more than offset these limited attempts. Wortis and Stone have expressed their concern about this threat to the integrity of the psychiatric profession in an editorial in a 1992 issue of *Biological Psychiatry*: ". . . professional psychiatric societies such as the American Psychiatric Association, the American College of Neuropsychopharmacology, and our own Society of Biological Psychiatry are becoming increasingly dependent on drug-company support" (p. 847).

A number of studies have suggested that drug advertisements have been aimed at extending the indications for prescription of psychoactive drugs into the "problems of daily living" (de Bakey, 1977; Kleinman and Cohen, 1991; Seidenberg, 1971), a result that appears to have been achieved (Kieffer, 1988). The drug companies have been an important factor in turning the vision of community mental health into little more than a market for their products. Deinstitutionalization clearly benefited the drug companies, since the removal of asylum walls contributed to a blurring of the distinctions between those considered severely and mildly mentally ill, making it easier to reach a vast new market of stressed and troubled people.

There is some evidence that the National Institute for Mental Health, the major United States funding agency in that field, and the National Alliance for the Mentally Ill (NAMI), a patient/family lobbying group in the United States numbering more than 100,000 members, are accepting financial support from pharmaceutical companies (e.g., conference sponsorships, drug "scholarships" to NAMI parents) [Breggin, 1991]. The National Mental Health Association (United States) has been criticized for "grey silence" on patient rights and for accepting millions of dollars from a pharmaceutical company for a "public service" campaign on depression (Oaks, 1993).

Issue advocacy groups. The patients, clients, and survivors of the mental health system have never had a major effective lobby group that was not dominated, initially or eventually, by other interests. A number of reasons explain the difficulty of mental health consumers in representing their own interests, not the least of which are the effects of treatment and stigma and the difficulty in obtaining financial resources compared to other interests (Chamberlin, 1990; McCubbin and Cohen, 1994; Mechanic and Rochefort, 1990). The major patient advocate groups are dominated by the patients' parents, whose interests diverge from those of patients (Cohen and McCubbin, 1990; Scull, 1990). While most parents can be considered to be motivated by feelings of compassion and the desire to see their children helped and their suffering reduced, they also wish to avoid blame for their own shortcomings as parents, avoid embarrassment and stigma associated with having mental illness in the family, and reduce tension and conflict in family interactions. While there is nothing wrong with having such desires, they can be expected

to influence parent perspectives such that parents should be regarded as representing their own interests rather than those of their children or other family members.

The family lobby groups have been conspicuous for their lack of pressure to implement the psychosocial aspects of the community care model. Instead, they vociferously put forward the idea that mental illness is simply a brain disease (frequently referred to today as "chemical imbalance"), and lobby for funding of biochemical rather than psychosocial research. As is obvious with the gun and anti-abortion lobbies in the United States, relatively small groups with highly committed and well-organized members, and good financing, can have an influence on policy far out of proportion to their membership. Insofar as this power is due simply to intensity of preferences, it can be justifiable in a well-designed political system (Congleton, 1991). However, if such power results from a major structural imbalance in access to the means for democratic participation, the political system is malfunctioning, such that policy inputs like the *Community Mental Health Centers Act* are severely distorted as institutional outputs (Jones, 1988), expanding anomalies in the political bargaining structure (Frey and Eichenberger, 1991). Without super-systemic correction, power begets more power, resulting in an increasingly irrational system.

The psychiatric profession. During the 1960s the psychiatric profession supported the transition from asylum to community mental health care, including the provision of psychosocial assistance. This support was consistent with their interests (MacLennan, 1989). In the years prior to deinstitutionalization psychiatrists were serving two main markets.

One market was the institutionalized population. Treatment of those persons provided relatively little in the way of financial remuneration, professional satisfaction, or status within the community (Scull, 1990). Most asylums were severely underfunded compared to hospitals (Carroll, 1969), the ratio of patient to practitioner extremely high (Wald and Friedman, 1978), and the public perception of asylum psychiatrists turned increasingly negative (Dain, 1989).

The other main market consisted of those well-to-do people and their families who were able to pay for psychotherapy. This had been a solidly growing market, but limited insofar as only the financially capable — or those able to obtain insurance — could access the services (Rochefort and Portz, 1993). Psychotherapy also acquired a tarnish during the 1960s as media portrayals often satirized its practitioners as ineffective, unscientific, and mercenary (Gabbard and Gabbard, 1987). In addition, the field was being invaded by other professions and even by non-professional practitioners.

Community care opened up a huge new market, ostensibly for "social psychiatry," financed by the public purse. Not only could many former asylum

inmates be treated in environments more conducive to the psychiatrist's comfort and status, but further expansion of diagnostic labelling could bring in new categories of patients including the stressed, anxious, and well-dressed, most of whom would not have been in the mental health system in prior decades.

In retrospect, it would appear that initially supporting a new model of community care was a strategically wise choice for the psychiatric profession. The vision of how that model might look down the road motivated the government in reducing asylum populations, and the provision of financing for out-patient psychiatric care facilitated access of psychiatrists to patients in the community. Once psychiatrists reached this community market, however, the considerations facing them were changed. Psychiatrists now had the prospect of not only serving a greatly expanded market, but of obtaining the scientific status which accrued to the medical specialties, and protecting their turf, which was being increasingly threatened by other professions active in the fledgling CMHCs (Light, 1985). The psychiatric profession then began to orient toward a biochemical model and sought to replace the idea of "community centre" with that of "clinic in the community," modelled after hospitals or simply run as adjuncts to or wards of hospitals. This orientation has been supported by the tendency of governments to treat mental health policy as a subset of a health policy centered around the hospital which "is regarded as the doctors' workshop — which others pay for but physicians control" (Kiesler, 1992, p. 1080).

Further, the increasing availability and acceptance of psychoactive drugs allowed psychiatrists to function like other medical doctors, dispensing drugs as an act of symbolism enhancing the mystique of the profession (Illich, 1977; Zola, 1978; see Haas and Shaffir, 1982; Lupton, 1993) and providing a mechanism for coping with the uncertainties inherent in the objectives of the profession (Gerrity, Earp, DeVellis, and Light, 1992). Furthermore, the drugs reduced various symptoms considered to be problematic. The ability to actually alter behaviour with drugs allowed for the new narrative of the psychiatric profession to arise: that even if the illnesses were not yet being cured, suffering was reduced and the approach was on the right track to eventually discovering biochemical or genetic markers for which more precise treatments could be devised. This narrative is not only reinforced by families and drug companies, but also by the media, which for many years has trumpeted the latest "discovery" of a schizophrenia gene — while the subsequent replication failures or retractions of earlier findings have received little or no press (Horgan, 1993).

The Further Commodification of Mental Health

Due to the mediation of powerful social institutions such as government bureaucracies, drug companies, families, and the psychiatric profession, another unfortunate consequence of deinstitutionalization was the further commodification of mental health: new products, services and customers were created (Ehrenreich and Ehrenreich, 1971; Ingleby, 1985). That new market came to be served by the "treatment in the community" model. The process of commodification, according to Renaud (1978), invariably follows major social engineering attempts of governments to improve the health systems of capitalist countries. Certainly, the existence of markets in the health field, the entrepreneurial nature of the psychiatric profession, the monopoly powers accorded to the professions, and the exceptional power of medical professions to avoid external regulation — conditions which are generally more marked in the United States than in Canada — impair the ability of governments to "rationally" restructure the mental health system.

The Policy Problem

Collective Paralysis

The major events characterising the rise and stall of the community care model took place over a mere ten-year period, roughly between 1965 and 1975. Pessimistic analyses, often sounding like post-mortems, began immediately after. As the years pass we gain historical perspective: not only do we have the benefit of the experience from intervening years, but as past events become more distant we tend to place them in an earlier as well as later historical context. Hence we can expect the community care initiatives to be subject to continuous or periodic reevaluation in the future.

Too narrow a temporal perspective can result in interpretations which are not only spurious, in the statistical sense, but overly confined to determinisms and fatalisms. A tendency in the recent mental health policy literature sees deinstitutionalization as largely the result of economic and fiscal factors, a view which is reinforced by the failure of governments to spend the money necessary to complete the community mental health care system. The implication of this narrative is that "we can't afford it," that the ideas behind the model have been proven false or unworkable, or that we, as a society, feel that "it's not worth it."

The overly pessimistic prevailing postmortem analysis of the consequences of deinstitutionalization seems to suggest the inevitability of the process that resulted in a technocratic care system that operates "in the community" by

simply dispensing drugs (e.g., Johnson, 1990). The feeling seems to be that uncaring governments and the public cloaked cost-saving measures with rhetoric about tolerance and normalization, and about the enabling and caring potential of communities. It is perceived that the public never had the will to complete what it pretended to set out to do.

Even if there is some truth in this perspective, it has created problems for society because it orients us to our failures and selfishness. The analysis of how social institutions such as drug companies, families, and health professionals have adapted to and guided policy interventions in their environments has revealed how relatively narrow self-interest can sabotage reforms whose objectives are shared by a large number of individuals or higher-level collectivities. Indeed, aside from the diversity of opinion within groups — a diversity which groups generally try to suppress — an individual may have many conflicting identities: e.g., the psychiatrist who feels, given the options currently available, that drug treatment is preferred, that his or her profession should lobby for more money to be directed to genetic research into schizophrenia, yet at the same time, both as a psychiatrist and as a person, feels that the mental health system would be better if it adopted a much more ecological approach to etiology, research, treatment, care, and support. The problem is a public choice problem, characterized by the paradox of the prisoner's dilemma. Individuals chart short-term, self-interested strategies, eschewing the strategies they might plot as members of higher-order collectivities, perceiving that they have little influence on the "system," and that other individuals will also act in the same way.

For a brief period during the 1960s, various elements coalesced and increased optimism that, as a society, we could successfully work together to achieve higher level collective goals. It was in this period of collective empowerment that both the rhetoric and experiments of community care had their heyday, inspired generally by social thought and movements envisaging a society of greater tolerance, wider participation, and a more ecological concept of the world and humanity's place in it, and by counterparts of these social developments in critiques of the asylum system as dehumanizing. The difficulties encountered (often resulting in worsened circumstances for those labelled mentally ill, especially those more severely impaired or marginalized, who found themselves homeless, suffering from iatrogenic diseases, or still warehoused in institutions, whether or not they are called asylums) have reduced our confidence that we can solve social problems and act collectively, as communities, to progress toward goals — explicit or amorphous — which we feel in our heart(s) are more just, humane, and ethical, as well as efficacious over the long-run.

Major reform of the mental health system does indeed seem virtually hopeless today, unless individually and collectively we begin to accept

responsibility for the system as a whole. This means not only acknowledging its failures as our own, but also accepting some credit for our tentative initial steps toward reform. This would mean, as proposed by Scull in referring to the "lunacy reform movement" of over a century ago, accepting that there has been an "authentic shift in moral consciousness," and rejecting the "crude reductionism" which seeks to explain the humanitarian sensibility as produced by material or economic interests (1985, p. 134).

Toward a Teleological Policy Planning Approach

The bulk of this paper has been devoted to an attack on economic determinist arguments — cost and fiscal factors — as the "cause" of deinstitutionalization, and to how social institutions transformed the community care objectives of health planners. Implicit or explicit throughout is a competing argument as to what broad factor is crucial in finding meaning behind the changes in the mental health system: that of actor choice — whether actors be conceived as individuals or collectivities. The emphasis on choice implies a teleological rather than determinist perspective, if choice is understood, as it is here, as being freely made within generally non-binding constraints.

Incremental policy. Simmons (1990) has described the development and implementation of mental health policy in Ontario as "incremental," noting that the future success of community mental health care "is by no means assured" (p. 267). Particularly because of the rise in recent years of a number of powerful non-client constituencies, Simmons argues the necessity of long-range strategic government planning. The mental health policy system has become increasingly unpredictable, particularly as a result of incremental changes, each of which not only modifies service institutions and delivery mechanisms, but creates a new political environment. Hence the system suffers from the "Butterfly Effect" — as the term has been used by Gleick (1987) to illustrate the difficulties in weather and macroeconomic forecasting and planning.

It is becoming increasingly clear that not only do client interests suffer during the minor policy skirmishes, but that the compromises resulting from incremental policy making can greatly alter long-term trajectories. For example, locating community care clinics in hospitals as an "interim" step has created new vested interests that may render further transformations increasingly difficult to achieve. There is no good reason, theoretically or given our experience in social engineering, to think that an incremental approach provides "steps in the right direction." Every change in the system creates a new environment; changed social structures change constraints which change preferences (Etzioni, 1988). Furthermore, social institutions seek to maintain their identities in adapting to interventions by cooptation (Ehrenreich and

Ehrenreich, 1978) and other compensating adjustments which, according to Crozier and Friedberg (1977), more or less totally transform the sense of reforms.

Political strategy. Therefore, a fundamental element of a strategic plan is a *political* strategy. As opposed to technocratic planning which merely inserts new structures within existing social and economic contexts, a political strategy would recognize the power and interests of the various actors within the system with a view to introducing or enhancing constraints or incentives to facilitate policy implementation. At this stage it appears that the emphasis should not be on mental health policy in a narrow sense but on the policy *environment*. While the purpose of this paper is not to develop policy proposals but to help clarify our understanding of the circumstances within which policy is made and distorted, this paper raises certain issues which should be addressed by a strategic policy emphasizing an improvement of the policy environment. Are there ways to reduce the stigma of ascribed mental illness, felt by clients and families, without overemphasizing biochemical attributions? Can the financial power of pharmaceutical companies to promote their products and influence policy and practice be justified? Are academics and medical practitioners, universities and professional bodies, excessively vulnerable to at least the appearance of conflicts of interest as a result of pharmaceutical funding? Can the formation of mental health policy within governments escape the umbrella of *health* (particularly insofar as health policy is concerned with hospitals and medicine)? How can goverments integrate for distressed clients a wide variety of social services, when those services are administered under separate bureaucracies?

The Will to Change

As Bateson (1972) suggested, the most intractable problems may require for solution a leap of faith, an almost paradoxical effort to emerge into a higher level of consciousness — in effect, to learn how to change our own identity, becoming dynamic rather than static personalities. This advice is applicable to the mental health policy field: we need to retain sight of our goals, the ethical outcomes we seek, and avoid demoralization due to dwelling excessively upon static and deterministic constructions of our present and past.

There is an obvious irony in this article's proposal to address the policy environment in order to reduce the influence of powerful interests which have already shown their ability to thwart major policy initiatives in the past. Given the disillusionment resulting from our inability thus far to achieve the objectives of community care, a revitalization of our collective will is called for by reopening the most fundamental questions that must

underly policy for its expression to be coherent. Are we really more willing to tolerate the deviances that we label "mental illness"? Do we yet recognize distressed persons as multi-dimensional social beings with needs that can only be met by and within community? Is the "community care" approach simply another service modality designed to meet a broader variety of needs, or does it reflect a more pragmatic view of "mental illness" as human problems?

Refocusing on these questions is an essential prerequisite to achieving true mental health policy reform. However, even if society were able to commit itself to a radically different paradigm of "mental illness," the actual power arrangements of the system are bound to divert us away from our ultimate goals. This article strongly suggests, therefore, that the mental health policy literature must progress beyond detailing the litany of incremental policy failures, to explicit consideration of how the distribution of power constraining the system can and should be altered. Those with power within the system must not, *by default*, be allowed to shape the mental health policy of a fair and democratic society.

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