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The limitations of the movement for deinstitutionalization of the chronically mentally disordered have been the subject of a repeated series of investigations and analyses in the last 10 years. These critiques can be summed up in the undeniable observation that the chronically mentally disordered have by and large failed to benefit from deinstitutionalization in the ways that the original advocates and planners of this policy had hoped. The promise of community mental health, at least as articulated by the scores of witnesses before Congressional committees in the early 1960's, has not been realized for this population.

The limitations of the movement for deinstitutionalization of the chronically mentally disordered have been the subject of a repeated series of investigations and analyses in the last 10 years. These critiques can be summed up in the undeniable observation that the chronically mentally disordered have by and large failed to benefit from deinstitutionalization in the ways that the original advocates and planners of this policy had hoped. The promise of community mental health, at least as articulated by the scores of witnesses before Congressional committees in the early 1960's, has not been realized for this population. As Leona Bachrach observed in 1983 about the plight of the chronically mentally disordered, "it is widely acknowledged that the target population in its entirety is today less than adequately and humanely served by existing programs" (Bachrach, 1983, p. 11). The serious limitations of deinstitutionalization to provide a more humane, therapeutic and cost-effective means of caring for the chronically mentally disordered has been repeatedly lamented (Bachrach, 1984; Bachrach, 1986; Gralnick, 1985; Lamb, 1984; Talbot, 1985). Many disturbed persons find themselves leading marginal and unproductive lives outside the mental hospitals,

contrary to what the sponsors of the movement for community mental health had hoped. Deinstitutionalization and community mental health were inextricably linked in the minds of the visionaries of the 1960s and early 1970s, but the reality is that deinstitutionalization has impacted one population, while community mental health programs have ended up meeting the needs of an entirely different population: middle class persons with less serious disturbances (Goldman, Adams, and Taube, 1983). In the community the chronically disturbed can be found in nursing homes, board and care facilities that offer little or no therapeutic treatment, and in inpatient units of general hospitals (Goldman, et al. 1983; Goldman, Feder, and Scanlon, 1986; Talbot and Sharfstein, 1986; Schoonover and Bassuk, 1983). According to some, the term "transinstitutionalization" arguably describes what has occurred better than deinstitutionalization (Bellack and Mueser, 1986). Many other chronically disturbed persons are now homeless, by their presence contributing to the rising quota of human misery inherent in what has become one of the most critical social problems of the 1980s (Lehman, 1983).

The problems of deinstitutionalization are so serious that some mental health professionals have been urging a return to the concept of the asylum as a refuge for the chronic mentally disordered (Bachrach, 1984; Gralnick, 1985; Talbot, 1984; Sigel, 1984; Lamb and Peele, 1984). Whether in state mental hospitals or in other places of care and treatment, this population clearly needs some other form of environment than the emptiness of board and care facilities or the anxieties of street life.

Among the most commonly mentioned reasons for problems with deinstitutionalization are the fragmentation of services for the chronically disturbed in the community, the underfunding of community mental health programs by various levels of government, the demand for community mental health services from a less disturbed population of mental health seekers, the movement of psychiatry out of community mental health centers, the inability of many chronically disturbed persons to take advantage of whatever mental health treatment is available in the community, and the failure of any community mental health programs to offer a viable substitute for the total care that was offered by the state mental hospitals (Bachrach, 1984; Talbot,

1985; Lamb, 1984; Goldman et al. 1983; Lamb and Peele, 1984; Panzetta, 1985). The problem of stigma has been acknowledged to be a continuing one, both within the mental health profession and in the community at large (Gralnick, 1983; Sigel, 1984; Mirabi, Weinman, Magnetti, and Keppeler, 1985). Bachrach pointed out that the term community itself is fraught with unrealistic associations of warmth, acceptance and localism (Bachrach, 1983). These inferences cannot be drawn from the contemporary communities into which the chronically disturbed have been released. Most communities did not welcome those with chronic mental disorders, in fact contact with these persons has been threatening to many in the community, who often have reacted with anxiety and efforts to limit their proximity.

The great reluctance of persons in the community to accept the mentally disordered is one of the most important reasons for the failure of community mental health to make a positive difference in their lives. This failure is rooted deep in our history and is linked to the reasons the severely mentally disordered were removed from local communities in the first place. A look at this history offers some clues about the reasons for the problems surrounding deinstitutionalization.

In Colonial New England insane persons lived with their families or in the homes of friends or neighbors. Mentally disordered members of the community lived out their lives with little or no interference from others. Few efforts were made to control them unless they directly threatened other townfolk with violence; the records indicate that these instances were relatively infrequent. Families and friends provided the distracted with the necessities of life when they were able to do so. Those without such resources were cared for in the same way as were other paupers; either boarded out with local families at town expense, or in the case of larger towns such as Boston, placed in local almshouses. No distinction was made between sane and insane paupers in these places of care (Records of the Overseers of the Poor, Boston, Mass; Records of the Overseers of the Poor, Concord, Mass.; Records of the Overseers of the Poor, Danvers, Mass.; Records of the Overseers of the Poor, Salem, Mass.).

The insane were expected to be productive members of the community even while they were exhibiting behaviors that we

would consider a sign of severe mental disorder. Sometimes a particularly violent outburst of madness would necessitate a temporary retreat from active participation in the life of the community, but a return was expected and usually accomplished. The most famous example of this continuing productivity is provided by the career of the political leader James Otis. In 1770 Otis, the great pre-Revolutionary leader and advocate, exploded in a "mad freak" and broke all the windows in Boston's town hall. He then "madly fired an assortment of guns out of the windows of his Boston home." Otis' friends quietly removed him to a private home in the countryside where he stayed a few months, to re-enter Massachusetts society as a member of the provincial assembly. Within a year he had relapsed: "he raved, jumped out of windows and was pitifully bewildered to find his clients seeking other assistance." Although afflicted with intermittent spells of madness, Otis continued to play an important role in the province's political life throughout the pre-Revolutionary years (Shipton, 1949).

Otis' prominence in the community was not a crucial factor in the community's expectation that he would continue to function. Samuel Coolidge, an errant Harvard graduate who disrupted that campus many times with his abusive behavior, was kept as a schoolmaster in Watertown. In the habit of wandering about the town in a dazed condition, often half dressed, Coolidge was a familiar figure there and in neighboring towns. The town paid for his board and keep in the home of a local family, but they expected him to return fair value for his support by serving as the town schoolmaster. When Coolidge became particularly unruly or began to roam, the town selectmen resorted to locking him in the school room all night so that he would be present for his classes! Coolidge was generally not violent, instead he was given to "great Horrors and Despairs. "There was no question that he was unequivocally mad though; in 1745 he was dragged out of the Harvard commencement "like a Dead dog in the presence of all the Assembly . . . on account of "his Distractions and Delirium." Eventually Coolidge's behavior became unruly and the townspeople were forced to find a sterner solution. In the last year of his life he lived in a locked room in the home of one family in the town, after several others had

refused to board him because of his fractiousness (Shipton, 1943).

The decision to lock up an insane person was not a common one in the colonial period, contrary to the popular myth about the barbarity of this era. Suspected witches, who assaulted the religious fabric of the society were treated harshly in colonial New England, but the insane were not. Insanity and witchcraft were considered very distinct phenomena; for the former a considerable amount of tolerance existed (Demos, 1982).

The term insane was rarely used in colonial New England; instead, mentally disordered persons were thought to be "distracted". This is the descriptive term that appears everywhere in colonial records, alongside the more legal phrase, *non compos mentis*. The term distraction suggests a gentler view of madness than what was to follow in the nineteenth century.

Another famous distracted man in colonial New England was Joseph "Handkerchief" Moody, a minister who began to wear a handkerchief over his face in 1738 and never appeared in public without it after that. Immortalized in a story by Nathaniel Hawthorne ("The Minister's Black Veil"), after 1740 Moody could not face his congregation and turned his back toward them even as he conducted church services. His congregation tolerated Moody in this state for three years before they brought in another minister to help him with the services. Moody continued to preach in the church and minister to the congregation as best he could for the next 12 years. A colleague of Moody's, Samuel Checkley, suffered a series of personal losses in the middle of the eighteenth century and from that time forward was unable to speak without weeping. He later began delivering his sermons in gibberish; even then his congregation did not fire him (as they had the right to do), but instead hired someone to help him (Shipton, 1942).

Both ministers were considered distracted by their congregations, friends and families; yet they were expected to continue to function in their roles as clergymen. The community in eighteenth century New England exercised considerable patience in the face of inexplicable, exasperating and clearly mad behavior. More examples of what seems to us a puzzling lack of concern for mental disorder can be found in the historical records, es-

pecially among the ranks of ministers and schoolteachers. This relative tolerance was also extended to poorer mentally disordered persons in these towns. While those distracted without means of support were cared for at town expense, it was their financial dependence, not their madness that brought them to the attention of local officials. As in the case of Coolidge, such persons might be considered a financial burden, but they would not be confined as long as they were not violent (Records of the Overseers of the Poor, Boston; Concord; Danvers; Salem).

Given their reaction to madness, it is not surprising that the colonists had a different understanding of madness than our own. The prevailing idea was that insanity was largely a supernatural matter; the result of a moral drama involving God, the devil and the distracted person. The scheme of causation was flexible, for insanity could be a test from God or a punishment from God, depending on whether the person so afflicted was thought to be a holy person or a someone who had clearly sinned. In the early decades of the eighteenth century it was thought that the devil could tempt or drive someone into madness; in extreme cases this could mean that the afflicted person was possessed by the devil. Whether the insane person was at fault in such cases depended again on the general perception of his or her guilt or innocence. After the middle of the eighteenth century, the belief in the direct power of the devil to cause madness was replaced by a more general notion that the mysterious workings of God's Providence was responsible.

The colonist believed that the body was implicated in insanity and there were various versions about which bodily systems were most likely to be affected by madness. The somatic causes were not thought to be primary but rather a part of a complex mix of supernatural and natural causes. This system might seem confusing and even contradictory to us, but it posed little problems for the eighteenth century New Englander, who viewed the natural and supernatural realms as inextricably linked. In 1702 Cotton Mather, the Puritan Divine, described the "black melancholy" that had overtaken a fellow minister, William Thompson. Satan, according to Mather, had become "irritated by the evangelic labours of this holy man and obtained the liberty to throw him into a Balneum Diaboli." Mather did not think that

Thompson's condition was his own fault, but he warned that some men "afford a bed wherein busy and bloody devils have a sort of lodging provided for them." This "bed" is the "mass of blood . . . disordered with some fiery acid. . . . Juices, ferments and vapours" all played a role in making men receptive to the machinations of ths devil. Mather thought the supernatural order worked through the natural sphere to drive a man to madness, for "humors . . . yield the steams when Satan does insinuate himself until he has gained a sort of possession in them, or at least an opportunity to shoot into the mind as many fiery darts as may causes a sad life to them" (Mather, 1702, p. 439). Insanity was an opportunity for a spiritual lesson, and Mather saw no conflict in uniting the spiritual and biological aspects of human nature in explaining it.

The explanations of the causes and meaning of insanity were directly linked to the kind of attempts to help or treat the insane in New England in this period. The most likely response was prayer and fasting. It was common for ministers and friends of the insane to call for days of prayer and fasting for their distracted neighbors, just as they did for those suffering from smallpox or other illnesses (Jimenez, 1987; Shryock, 1966; Starr, 1982). Since the disorder was at least partly a spiritual affair, it made sense to ask for supernatural intercession. After all, God was the source of the ultimate power over all matters, and could lift the spell of distraction. Medical remedies were sometimes used in cases of insanity, especially in the late eighteenth century. Although the state of medical practice in New England was far behind the level of England at this time, physicians there employed the standard practices of heroic medicine suggested by English writers including bleeding, blistering and the use of purges and emetics. These treatments were often combined with dosages of plant and animal extractions known as "pharmacopeia" (Shryock, 1966; Starr, 1982).

Clearly the lack of systematic response to the distracted residents of colonial New England was related to the paucity of resources available to solve any social problem. The colonists had built only one hospital, for the reception of small pox victims who needed to be isolated from others; there were no institutions for the developmentally disabled, no orphanages, no

elaborate prison system (Blake, 1959). Neither the excess financial resources nor the instrumental cast of mind yet existed which would encourage a systematic effort to solve social problems or establish a social welfare or health system (Starr, 1982). Furthermore, the notions of prevention and cure of physical illness were not widely accepted as either possible or necessary in this society which looked to the supernatural order for the resolution of problems and which possessed a very rudimentaary medical technology incapable of solving even the most commonly occuring physical diseases (Starr, 1982).

Yet none of these reasons seem to have been the most significant ones informing the response to insanity in colonial New England; a response which to contemporary observers might seem neglectful rather than tolerant. For when the post-Revolutionary generation did confine the insane, they did so in the same structures that dotted the landscape of the colonial towns: jails and almshouses. The most important reason for the reaction of the colonist to insanity can be found in the structure of New England society in the eighteenth century.

Before the American Revolution most New Englanders lived in very small towns, characterized by a great deal of personal interaction and face to face knowledge of other residents. Life was considerably less complex than what was to follow in the nineteenth century: economic choices were minimized as most townsfolk were subsistence farmers or artisans working in small trades. There were few consumer goods and little cash in the economy, instead economic transactions usually were accomplished by trade or barter. Even in the larger towns in the aras, such as Boston and Salem, economic relationships were carried on in the context of family relationships; the cash nexus was not primary. Political choices were minimized, as voting for local offices was more of a ratification of local elite based on deference, rather than a democratic choice based on competing political actors. Family relationships were the key ones in this pre-modern world. Family members lived near each other and formed primary social bonds. A very powerful system of social control existed in Colonial New England, in the close proximity of family members, in the personal nature of smalltown life, and in more formal mechanisms of control wherein local officials patrolled the towns looking for any signs of moral deviance. Such

provisions for control of behavior existed even in the larger, commercial centers of the area, although of course, life was more complex in these places (See Tracy, 1979; Jedrey, 1979; Lockridge, 1970; Nash, 1979; Cott, 1976).

In this society individuals were caught in an intricate net of expectations that effectively limited individual decision-making and behavior. The necessity for internal control of behavior was minimized because a very strong system of external controls was paramount and guided social interactions. Under these circumstances, the lack of control implicit in mentally disordered behavior was not as threatening as it was to be later. Unless the distracted directly threatened the safety of others, they were of little concern.

The inexplicable or seemingly meaningless nature of insane behavior was also less threatening in a society which provided a widely held explanation of this anomalous behavior. Insanity was firmly embedded in the supernatural context that provided an explanation for most of life's events in colonial New England. As a manifestation of God's mysterious Providence or the devil's ubiquitous threat, distraction was understandable and in some sense, acceptable.

After the American Revolution the newly formed New England states passed laws confining the mentally disordered in existing local facilities. All over the region, the distracted were locked in jails, in separate rooms and cells in almshouses and in private homes. Well before the founding of the medical asylum for the insane, local officials had found it necessary to remove their distracted friends and neighbors from the community. At the same time that jails and local almshouses began to receive these disturbed persons, families began confining insane members at home, often under unpleasant circumstances (Records of the Overseers of the Poor for Boston, Concrd, Danvers, Salem). Reformers did not become interested in the plight of these distressed persons until the 1820s and 1830s, when a spirit of reform swept Jacksonian America. Before the founding of private asylums based on the humane principles of moral treatment began to be established in the 1820s and 1830s, the majority of mentally disordered persons had been removed from New England society.

What prompted the confinement of the insane in New Eng-

land? As one might expect, the understanding of insanity had changed dramatically, but more significantly, the New England social order had undergone profound changes after the Revolution. By the end of the eighteenth century the colonial world had passed, to be slowly replaced by a more complex, urban, democractic, competitive one. Population increased all over New England; Massachusetts was becoming increasingly urban after 1790 (Vinovskis, 1975). Increased geographic mobility meant that people were more likely to be living near strangers and recreating their social lives with greater frequency. Accompanying the increased migration was an increased number of transients in Massachusetts towns. More systematic measures for controlling strangers were devised to replace the older system of warning out (Jones, 1981). With independence came the development of a far more complex economic infrastructure, marked by the decline of household manufacturing, the rise of textile manufacture, and the growth of a regional market economy (Ware, 1931; Rothenberg, 1981). As a result of these changes, wage labor began to replace subsistence farming and the work of artisans. Increasing wealth stratification led to a growing class of poor and unskilled workers and a marked increase in economic inequality in the early decades of the nineteenth century (Lindert and Williamson, 1976). All these changes made far greater demands for competition and individual functioning, as economic survival was now more and more dependent on a solitary struggle for the means of subsistence. Demands for individual decision-making in the form of political participation increased as well under the new federal and state constitutions which considerably broadened the number of elected offices. These changes led to the rise of a cosmopolitan outlook, replacing the more parochial mind-set of the colonial period, as a plurality of associations unravelled the web of family and neighborly relationships that had surrounded individuals in that more orderly world (Tracy, 1979; Kaestle and Vinovskis, 1980; Gross, 1976; Doherty, 1977; Brown, 1974). As community life was becoming more fragmented, individualism and competition began to replace the earlier ideal of communitarianism (Tracy, 1979). No longer enmeshed in a thicket of external controls and expectations, people began more and more to forge their own social

reality and to be responsible for individual decisions and self-control.

New demands for individual performance and control rendered the behavior of the insane less acceptable, since they seemed to represent loss of control. In addition to these changes, the diminution of the Calvinist explanation of reality and the proliferation of religious sects accompanying the dis-establishment of religion in this country, combined with the rising tide of secularism, reduced the power of the earlier supernatural explanation of insanity (Ahlstrom, 1972; Goen, 1962). With the move to a more scientific, secular, medical view of human disability, the power of the supernatural certainties to disarm insanity was lost.

With what was it replaced? In the early nineteenth century, as the medical profession in the new Republic began to grow in numbers and eminence, physicians began to look seriously at the causes and treatment of insanity. Borrowing from the English conceptions of insanity, those who speculated on its nature linked the onset of madness to an excess of passions and personal vices, especially masturbation and intemperance. Such beliefs led naturally to a vigorous application of the older palliative of heroic medicine, as well as to the development of new methods to encourage the insane to control themselves. The issue of control became central to the thinking about insanity in the medical profession. Maniac and melancholiac replaced the homlier and presumably less scientific term, distracted. Both the language of insanity and the reaction to the insane became more passionate in the early years of the Republic.

Benjamin Rush, a pioneer in the medical treatment of the insane, believed that maniacs could sometimes be cured with what he called "the fear of death," which he effected by near-drowning his patients. Blistering, bleeding, rotary swings, seasickness chairs and other like treatments may seem barbaric to the modern sensibility, but they were perfectly in keeping with the prevailing medical theory of the time, which was that madness was related to vascular tension (Rush believed this), or alternatively to noxious humors or inflammation of the brain. The somatic side of insanity was linked with an ethical side, in which the insane were often blamed for their condition, brought

on by their own lack of self-control (e.g., Cutbush, 1794; Anderson, 1796; Rush, 1786; Rush, 1812). This sense of blame lent increased vigor to the potential harshness of the medical treatments, which did not diminish the humanitarian impulse behind the efforts of the early reformers to help the insane in their care. Rush practiced at Pennsylvannia Hospital for the Insane, one of the earliest establishments of its kind (Tomes, 1984). Other physicians treated the insane in private practice. It must be emphasized, however, that the majority of the mentally disordered received no medical treatment at all, but lived, often under very trying conditions in local jails, almshouses and in private homes (Grob, 1973, Jimenez, 1987).

Moral treatment and the establishment of the public mental hospitals in the 1830s and 1840s ended this treatment for those who were admitted to the asylums which proliferated in the Northeast. Yet even as the public asylums were enlarged and reformers agitated for the establishment of more, other insane continued to be confined in local almshouses and jails. The movement to confine the insane by this time was inexorable (Grob, 1973).

The story of moral treatment, initially a successful and humane approach to helping the mentally disordered has been told elsewhere (Rothman, 1979). Eventually it too degenerated into an essentially nonmedical, custodial approach to the insane in the large state mental hospitals. These custodial hospitals remained the dominant solution to the problem presented by mental disorder until the emergence of deinstitutionalization.

Both contemporary evidence and a look at our history suggest that mentally disordered persons will not be welcomed in modern communities that are atomistic, competitive places calling for a high amount of individual rationality, decision making and self control. The stigma of mental disorder lies in the anxiety about lack of self-control (real or imagined) on the part of the mentally disordered. What is needed is a new social policy direction that takes into consideration the realities of our complex, urban society while meeting the security, treatment and other human needs of this vulnerable population.

Looking back at a time in our history when the mentally disordered living in the community were tolerated, leads to the

conclusion that we need to redirect our thinking about the most humane solutions for those who struggle with mental disorder today. The dream that towns and cities will absorb the mentally disordered into the economic and social fabric of modern life is not likely to be realized in the near future. For now, many of those suffering from serious mental disorder will continue to need places of refuge, at least temporarily, where they can have their most basic needs met and which will serve as buffers to the stresses of technological, individuated life. History also can offer a strong lesson on the folly of erecting large, custodial mental hospitals far removed from the community to which patients are to return. But smaller places of refuge *in* the community, perhaps similar to the halfway houses envisioned in the original Community Mental Health legislation, are a necessary step before total deinstitutionalization is embraced. These community based treatment centers need to emphasize resocialization programs to teach the mentally disordered the social skills critical to acceptance in the wider community. Programs emphasizing an educative approach, which systematically move the client to increasing mastery of independent living skills have been implemented in various community-based shelter care facilities (Farkas, 1987; Segal, 1979). These programs can make a critical difference in the ability of persons with serious mental disorders to eventually live *in* the community, because they can help reduce the behaviors that are seen as threatening by others. Relearning behaviors commonly accepted at the most basic level of social intercourse may enable many persons with serious mental disorders to partake in community life. But these programs may not be enough. The comforting external supports of life in the colonial period allowed many distracted persons to function in spite of their disability. By contrast, recent research on seriously disturbed psychiatric patients suggests that their social networks are smaller, include mostly kin, and are less varied than those of other persons (Cutler, 1987). In contemporary society, therefore, social support networks for seriously disturbed persons need to be provided through professional intervention. The development of "community support systems" or social support networks to provide mentally disordered persons with important linkages in the community is critical for

their well-being. When these approaches have been utilized in the form of socialization groups, case management and material supports such transitional living arrangements and vocational training, the results have been positive. One study showed that those who participated in case management and socialization groups experienced fewer psychiatric hospitalizations than those who did not (Cutler, 1987).

A major commitment to the concept of community support systems or social support networks, along with the development of community-based resocialization, social skills programs are both necessary to meet the critical needs of persons with serious mental disorders. Federal leadership is now necessary to address the problems created by the Community Mental Health legislation enacted over 20 years ago. One thing seems clear: the low cost approach of releasing the mentally disordered into communities with few programs for their care or treatment is based on a false understanding of the anxieties that mental disorder has evoked in this country since the early nineteenth century. Until we accept this reality, the possibilities of community mental health will remain unrealized.

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