Historical Context, Institutional Change, Organizational Structure, and the Mental Illness Career

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Abstract

This dissertation demonstrates how patients' mental illness treatment careers depend on the change and/or stability among differing levels of social structure. Theorists of the mental illness career tend to ignore the role that higher levels of social structural change have on individuals' mental illness career. Researchers using an organizational perspective tend to focus on the organizational environment but ignore the treatment process from the individual's point of view. Both perspectives neglect what the nation-state's broader socio-political and economic circumstances could imply for people seeking treatment for mental disorders. Organizational theory and theories of the mental illness career are independent theoretical streams that remain separate. This dissertation connects these independent theoretical streams by developing a unifying theoretical framework based on historical analysis. This historical analysis covers three phases of treatment beginning at the end of World War II to the present. This framework identifies mechanisms through which changes in larger levels of social structure can change the experience and career of mental patients. This new perspective challenges current conceptions of the mental illness career as static by accounting for the various levels of social structure that play a part in the mental illness treatment career. Taken together, the inclusion of differing levels of social structure and the subsequent reciprocal relationship between these levels of analysis produce a narrative that explains why and how stability and change within the mental health sector shape the mental illness treatment career.

Dedication:

To Howard (Doc) McLeskey Ph.D., (1943-2010) who taught me when working with those with mental illness, that my goal should not be to just help, but to listen and learn from their lives and stories.

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Introduction

Previous research situated an individual's mental illness career within an organizational context. Goffman (1961) and Rosenhan (1973), for example, considered the organizational context when examining mental illness careers highlighting how the organization affects patients' treatment careers. However, the organizational context has changed dramatically over the last 60 years. Conversely, contemporary literature analyzing the mental illness career typically focuses on an individualistic perspective while ignoring the role that larger social structural changes have on individuals' mental illness careers. For example, Aneshensel (1999) presents a mental illness career model in which individuals pass through three stages as their disorders and treatment episodes unfold over the life course (i.e., prepatient, patient, and post patient). While useful, these stages do not address structural arrangements within which individuals experience their mental illness careers. Situating these stages within an organizational context would reveal how organizational changes alter the mental illness career.

Furthermore, mental health research at the organizational level has typically investigated organizations in changing institutional environments (Polgar 2009) while ignoring individual mental illness careers. For example, Schlesinger and Gray (1999) analyzed increased proprietary ownership among psychiatric hospitals and managed care growth inside third party service payers. Their analysis, however, ignores how institutional processes affect the careers embedded within the changing organizational context. In addition, the circumstances of the nation-state, within which these institutional processes are generated, are often overlooked. It is important to remember that institutions operate within nation-states, and changes in broader societal, political, and

economic trends can affect various institutions which subsequently affect the organizational context within which people experience their mental illness careers.

Although both mental health treatment and organizational studies are indispensable, including different units of analysis (i.e., individual, intermediate, and macro levels) would benefit these studies. Moreover, it would provide insight regarding how social structural context and change affect mental illness treatment careers imbedded within these higher levels of analysis. It is my assumption that when changes in the socio-political and economic context of nation-states occur, institutional environments change. When the institutional environment (i.e., specialty mental health sector[1]) fluctuates, organizational forms[2] and behaviors[3] change; when organizations transform, this alters individuals' treatment careers embedded within the organization. This dissertation incorporates different units of analysis (i.e., socio-political and economic context of the United States, the mental health sector, and the organization) and new developments in organizational theory (i.e., neoinstitutionalism) to develop a cohesive theoretical framework that describes mental illness careers embedded within this social structural context.

The argument and analysis in this dissertation unfold as follows. First, I explain and critique the different theories of mental illness and mental illness treatment and the implications they have for predicting the mental illness treatment career in contemporary

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[1] The specialty mental health sector is a distinct component of the health care institution, which consists of roles, occupations, and organizations oriented exclusively to providing mental health treatments.

[2] Organizational form refers to the specific structure that each organization takes. Examples would be the state and county hospitals, V.A. hospitals, general hospitals with inpatient psychiatric wards, private psychiatric hospitals, free standing outpatient treatment centers, community mental health centers, and nursing homes.

[3] Organizational behavior refers to the specific organizational policies, procedures, and practices regarding treating patients with symptoms of mental disorders. An example would be the particular polices and practices state and county mental hospitals have for admission, treatment, and release.

times. Second, I describe neoinstitutional theory and its explanation for how the institutional environment affects organizational structure. Third, I discuss how the socio-political and economic context of a nation-state affects the institutional environment. Fourth, I review the literature on mental health treatment from 1945 to 2005 and use neoinstitutional theory to highlight the isomorphic processes underlying implementation and change in treatment regimes. After discussing the methods used to describe individuals' mental illness careers within a neoinstitutional context, I present three chapters that review the empirical data on the mental health sector over three, twenty year phases (i.e., institutional phase, community-based care phase, and the managed care phase). Finally, I conclude by explicating a theoretical framework for understanding how the mental health sector underwent a dramatic transformation over the last sixty years by highlighting mechanisms at different levels of analysis.

Chapter 1: The Conceptualization of Mental Illness and its Treatment Career

This chapter first reviews how previous theories have explained mental illness and mental illness treatments. Theories about mental illness and mental illness treatments typically omit organizational context within which diagnosis and treatment occur. I assume organizational context is an important component in theorizing about the mental illness career. Secondly, this chapter reviews an organizational theory that situates organizations within the larger institutional context, helping to explain changes in the conception of mental illness and patterns of treatment. Finally, it is important to remember institutions operate within a larger context (i.e., nation-states) and changes in this context can affect various institutions subsequently affecting the organizational context within which people experience their mental illness careers. This chapter concludes with a discussion of the role socio-political and economic contexts of a nation-state have on the institutional environment.

Asylums

Goffman's (1961) *Asylums* is an important contribution to the sociology of mental illness. Not only did this work have significant political and social consequences (Kirk 1999; Smith 2006), it also had important theoretical ramifications (Dowdall 1999). Goffman's analysis examined the place of treatment (the mental institution) providing a context for mental illness careers. He argued that a patient's mental illness career has three phases: prepatient, inpatient, and ex-patient. Goffman's (1961) "The Moral Career of the Mental Patient" addressed the first two phases (prepatient and inpatient); however, it did not include the process involved in releasing patients (ex-patient). The first phase examined factors leading patients to treatment through a funnel of betrayal, where accusers (i.e., next-of-kin

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and complainants) and mediators plotted to hospitalize the prepatient. The next phase examined the treatment of patients and documented the stripping of civilian identity (i.e., the mortification process).

Goffman (1961) suggested that patients entered treatment either voluntarily or involuntarily. His work examined involuntary forms of treatment suggesting they occurred because of one of three types of coercion. The first type of coercion, familial, occurred when family members petitioned or intimidated a member to go "willingly" into treatment (133). The second type of coercion, official, occurred when the police or other authorities escorted patients to the hospital. The third and final type of coercion, misapprehension, occurred when agents persuaded individuals to seek hospitalization; younger prepatients typically experienced this type of coercion.

Case histories documented the social beginnings of a mental illness career during the prepatient phase (Goffman 1961). According to Goffman, the social beginning of a mental illness career had no relationship to illness onset or the psychiatric understanding of mental illness. Case histories typically showed offenses against some social arrangement such as households, workplaces, semi-public organizations (i.e., churches and stores), and/or public areas (i.e., parks). According to Goffman (1961), "In this perspective the psychiatric view of a person becomes significant only in so far as this view itself alters his [the patient's] social fate—an alteration which seems to become fundamental in our society when, and only when, the person is put through the process of hospitalization" (128).

Goffman (1961) also argued, the number of mentally ill outside hospitals was equal to or more than those hospitalized; in other words patients endured contingencies and not mental illness (135). Contingencies brought individuals into contact with agents who

facilitated the transition from prepatient to patient. There are three types of agents: next-of-kin; complainant; and mediator. Next-of-kin agents (i.e., family or friend) tended to have the trust of the prepatient. Complainant agents took action against the offender which typically led to hospitalization. Mediator agents interacted with the prepatient and facilitated hospitalization. This interaction, referred to as the betrayal funnel, often included police, clergy, health care professionals, lawyers, social workers, and schoolteachers. In Goffman's (1961) words, "The betrayal funnel is the process where, the prepatient starts out with at least a portion of the rights, liberties, and satisfactions of the civilian and ends up on a psychiatric ward stripped of almost everything" (140).

When Goffman examined the inpatient phase, he described how patients were treated and emphasized the stripping of civilian identity (the mortification process). Inpatients had their supports, pleasures, and defenses removed and were then subjected to restricted movement, communal living, and staff with broad authority. During this process, inpatients were segregated into different wards based on different levels of social functioning also known as the ward system. Goffman (1961) argued that psychiatric doctrine "defines mental disorder as something that can have its roots in the patient's earliest years" (155) and viewed the ward system as assigning inpatients to different levels of social functioning. The belief was that this system would enable patients' progression from an infantile position to re-socialized adult within a year. Consequently, the ward system demonstrated how physical structures framed people's conceptions of themselves.

Paralleling the ward system's physical structure and its consequences on inpatients' self-perceptions, psychiatric interpretations of patients' actions also re-framed self-perceptions. First, Goffman argued patients develop a "sad tale" (152). A sad tale was an

explanation that justified patients' positions when confronted with past failures, internal problems, and misguided attitudes. However, since inpatients were detained against their will, those involved in patient detention—next-of-kin and staff—needed to justify treatments they imposed. As a result, staff discredited inpatients' sad tales by linking patients' case histories directly to their difficulties. This is what Goffman (1961) termed a "shameless game" (165); patients create an environment where building up a self or having it destroyed became a game. The mortification process did not necessarily change patients' perceptions about themselves; however, redefinition of one's self sometimes occurred when the patient embraced the psychiatric perspective and focused on improving themselves through treatment (Goffman 1961).

Although Goffman (1961) conceptualized patients' "social distance"[4] (130) from their situation as their problem, and not mental illness, his work is not a theory of mental illness and analyzes the effects of the asylum on patients. Consequently, the dependent characteristic was whether individuals were patients in a mental hospital not that they had mental illness. When analyzing how people entered treatment, Goffman (1961) described coerced routes into the hospital. Specifically, his work addressed how the betrayal funnel affected the prepatient, where accusers and mediators were viewed as plotting to hospitalize the prepatient. Goffman also examined how the mental hospital affected the inpatient career, where the treatment/control method was the mortification process, a stripped civilian identity. However, his analysis did not consider how patients were released from treatment. Goffman analyzed a particular type of organization at a particular time: the asylum. Consequently, his theory prevents the inclusion of other organizational forms where patients

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[4] Goffman's "social distance" referred to the agent's familiarity with the point of view of the person with mental illness

voluntarily seek treatment. Moreover, this theory neglects how organizational change affects mental illness careers. Additionally, his work is temporally nested within the asylum, suggesting that it would not be relevant for contemporary patients and how they engage in treatment.

In summary, Goffman (1961) focused on coercive forms of treatment. He argued the treatment process had a social beginning, which typically involved offenses against some social arrangement such as household establishments, workplaces, semi-public organizations (i.e., churches and stores), and/or public areas (i.e., parks). This offense led to interactions with agents that culminated in the betrayal funnel and facilitated the civilian to patient transition into the hospital. Once in the hospital, the mortification process was enacted in two ways: 1) implementation of the ward system, where the physical structure framed the way an individual conceived of him or herself, and 2) deconstruction of the patient's "sad tale" in order to perform custodial functions, control and maintain the patient, and impose treatment. This process may or may not have resulted in the patient's acceptance of the psychiatric perspective. Nevertheless, if a patient accepted the psychiatric perspective and improved with treatment, s/he was more likely to be released.

Labeling Theory

Goffman's (1961) work made a major contribution to labeling theories of deviance by focusing on the situations of people who were different and unusual (Smith 2006). Scheff's (1999) labeling theory of mental illness understands mental illness as violations of residual social norms. In particular, Scheff (1999) argued society categorizes norm violations, yet some norm violations do not fit these categories. Society may classify unnamed norm violations together in a residual category (i.e., mental

illness) such that the career of those labeled as residual deviants depends on social response and role-playing. Thus, labeling theory argues, most psychiatric symptoms are instances of residual rule breaking.

In the labeling process, residual deviants' most salient characteristics are the level, amount, and visibility of residual rule breaking. These factors are essential when considering the severity of public reaction. The next critical aspect of public reaction constitutes the rule breakers' power, the social distance between persons with mental illness, and agents of control. Finally, a community's tolerance level and the attainability of alternative roles in a community affect public reaction. For example, a person could be considered eccentric rather than mentally ill. Consequently, according to labeling theory, being labeled mentally ill begins patients' engagement in treatment suggesting that the labeling process creates mental illness (Scheff 1999).

In examining how people with mental illness are treated, Scheff (1999) analyzed interactions between deviants and authority figures. He argued that these interactions were negotiated and labeled deviants were rewarded for acting mentally ill. During the labeling process, deviants were suggestible and might have accepted the insanity role; their perception might have been that accepting this role was their only option. Patients were rewarded when they demonstrated knowledge of their deviant behavior and supported their diagnosis. Those who were labeled and attempted to return to standard roles were punished by authority figures (Scheff 1999). In other words, patients' support of their diagnosis implied a path out of treatment. However, labeling theory did not directly address requirements for patients' release from treatment. Nevertheless, these rewards and punishments led Scheff (1999) to argue that labeling caused the role of the

insane career. Scheff also assumed a coercive treatment process and its use of custodial care; this suggested the theory conceived organizational forms that corresponded to the asylum and static.

Unlike Goffman (1961), Scheff (1999) presented a theory about mental illness and how a person transitions from the prepatient to the patient phase. Specifically, he asserted that labeling causes mental illness careers. Whereas Goffman (1961) described how a person engaged in treatment and how treatment (i.e., total institution) affected patients, Scheff's (1999) theory did not go this far. However, Scheff's (1999) theory of mental illness has implications for treatment engagement and mental illness careers. Scheff's (1999) concern was with how professionals and nonprofessionals conceptualized "mental illness" and the characteristics that buffered residual deviants from societal reaction. He asserted that patients engaged in treatment by being labeled mentally ill. Moreover, the negotiation between authorities (i.e., psychiatrists and judges) and patients demonstrated coerced routes into treatment. Yet, this theory does not directly consider where treatment occurs (i.e., organization) and what happens when organizational forms (i.e., the place of treatment) change. Finally, this theory fails to address how patients are released from treatment; however, deviants' support for the label suggests one way out.

In summary, Scheff (1999) focused on coercive treatment engagement arguing that mental illness consisted of violations of residual norms and the severity of public reactions to those violations. Being labeled mentally ill began patients' engagement in treatment, suggesting that labeling created mental illness careers. Additionally, the careers of those labeled as mentally ill depended on social responses of others and their role-playing. For example, if society reacted negatively to the violation, the residual

deviant was referred to the proper authorities leading to an interaction between the deviant and authority figures. Deviants either received rewards for supporting their diagnosis by acting mentally ill or punishment when attempting to return to conventional roles. Thus, it seemed reinstatement into society required the deviant to support the assigned diagnosis and/or deviant label.

Psychiatric Perspective

Whereas labeling theory views society's reaction as creating mental illness, the psychiatric perspective uses a biological or medical model emphasizing individuals have a disease or disorder that produces symptoms (Horwitz 2002a). In other words, individuals who have psychiatric problems are suffering from a serious disturbance not a label placed on them by society (Gove 1970). Psychiatry conceptualizes mental illness as disorder or disease and categorizes different symptoms into essential characteristics (Bruce 1999; Horwitz 2002a). Subsequently, psychiatrists develop a treatment in response to symptoms (Bruce 1999). "Diagnoses form the major types of category and are defined, in large part, by clusters of signs and symptoms that are clinically meaningful in terms of personal distress, associated loss of functioning, or risk of negative outcomes such as death, disability, or loss of independence" (Bruce 1999: 39). Once classified, practitioners search for characteristics associated with the development of symptoms. Causes may be genetic, biological, psychological, or social (Horwitz 2002a).

From this perspective, people engage in treatment because they have serious psychiatric disorders. They do not engage because they were labeled mentally ill by society (Gove and Howell 1974). If people enter treatment, their symptoms are typically

treated according to the psychiatric conception of mental illness that is dominant at the time. Currently they are treated as discrete disorders or disease entities (Bruce 1999). Medical treatment uses psychotropic therapies with the possible combination of psychological counseling and social services. Patients discontinue treatment when their symptoms subside; however, relapse—when symptoms return—can occur (Mechanic 2008).

The psychiatric perspective is concerned with the conceptualization of mental illness as a distinct entity, patient characteristics as related to symptoms, and the career transition from prepatient to patient. This perspective is biologically and/or medically oriented viewing mental illness as a disorder or disease and postulates people engage in treatment to alleviate their symptoms, not because society reacts negatively. Treatment can occur in various organizations depending on the disorder's acuteness and/or chronicity. Treatment scenarios occur when people enter treatment both voluntarily and involuntarily. The psychiatric perspective does not depend on specific organizational forms; however, this perspective overlooks organizational forms and the effects organizational change has on treatment engagement.

In summary, the psychiatric perspective views mental illness as a disease or disorder stemming from genetic, biological, psychological, and/or social causes. People can enter medical or psychological treatment either voluntarily or involuntarily. Various organizational forms can be, and are, used to treat mental illness. Patients are released from treatment when symptoms are alleviated but may re-enter treatment if symptoms return.

Social Control of Mental Illness

Horwitz's (2002a) theoretical model focuses on the social control of mental illness within the social structure. He argued that when the social structure changed, society's mental health treatment structure was transformed. As a result, control shifted away from the family and toward the individual. Society now treats people with mental illness through more individualistic methods (i.e., voluntary treatment) rather than coercive forms of treatment (i.e., involuntary treatment). Horwitz's model presents four aspects of treatment engagement.

First, Horwitz's model considers behavioral characteristics of the mental illness label and perceptions warranting use of that label. These characteristics are important determinants of mental illness. Horwitz (2002a) contends that what is consistent across cultures is "the standard of incomprehensibility [which] provides a rough comparative concept of mental illness as a social construction that captures the essential nature of mental illness labels in a wide variety of times and places" (29).

Second, the model looks at different labeling conditions and how they matter. Horwitz (2002a) suggests that the application of a mental illness label is more likely to occur when the social distance between an authority figure (i.e., judge and/or mental health professional) and the deviant is significant. Thus, Horwitz's theory parallels Goffman's (1961) argument that a patient's mental illness is conceptualized by his/her social distance from the situation. Social distance is broken into two components: relational distance and cultural distance. "Relational distance refers to the extent of interpersonal involvement between people as indicated by factors such as the scope, frequency, length, and intimacy of their interaction…Cultural distance refers to the extent

to which individuals share characteristics such as ethnicity, lifestyle, or religious and political beliefs" (Horwitz 2002a: 34-35).

Third, the model examines how people get into treatment after being labeled mentally ill. Specifically, it examines whether the person with mental illness is excluded from, or included into, a social group (social distance). The model proposes that the strength of social resources and the social control that groups exercise (i.e., families, neighborhoods, and communities) influence the amount of exclusion people with mental illness will experience. Horwitz (2002a) then argues that treatment varies in different societies. Cohesive, non-stratified, and culturally similar groups exert the least amount of social control on people with mental illness. However, when social structure shifted toward the individual, society increasingly used exclusion. Individualistic societies use decentralized organizational forms to treat patients. Nevertheless, he argues that using coercive institutions to treat mental illness has decreased because social structure changed from the family to the individual undermining the control family had over its members. Individualism and all the legal rights it entails undermined the family's ability to define deviance, and thus undermined the family's ability to "commit" a member to a mental hospital. According to Horwitz (2002a), "As communities become collections of autonomous individuals, formal systems of control are less willing to invoke involuntary social control against the mentally ill but are more willing to uphold the rights of individuals" (xiii). Therefore, deinstitutionalization resulted from the changing units of social structures (Horwitz 2002a).

Finally, the model considers how people with mental illness are treated. Horwitz (2002a) argued that therapy and medication comprise the characteristics of social control.

He suggested that, increasingly, therapy and medication were the consequence of weakening communal and kinship structures, which shifted the burden to the individual and emphasized individualistic social structures. For example, he first discusses how psychotherapy induces changes in individual patients. The social distance between the therapist and patient influence how psychotherapy is performed and the amount of control used. The further the social distance between the therapist and patient the more coercive the relationship whereas the closer the social distance between the two leads to partnership. Next, he compared psychotherapy to "communal" social groups as a form of therapy. Communal groups produce change by promoting solidarity. These groups use a therapeutic style that promotes "ritualistic expression, social conformity, and collective participation" (Horwitz 2002a: 167). Subsequently, he proposed the hypothesis: As individualism develops, the form of therapeutic control shifts toward more individualistic therapies (Horwitz 2002a).

Horwitz's (2002a) work deals with societal reaction to mental illness and how people engage in treatment (i.e., the patient phase). When examining how people engage in treatments Horwitz (2002a) argues as social structure changes it influences mental illness careers. He argues that as involuntary treatment has declined voluntary treatment is increasingly the norm. Treatments have shifted toward individual perspectives using therapy and medication. This points to another assumption: the organizational form used for treatment is decentralized and treatment occurs in less restrictive environments where individualistic treatment is dispensed. Although this theory deals with social structural changes influencing treatment types and suggests treatment in more fragmented forms, it fails to account for how various organizational forms and behaviors affect patients'

treatment careers. His theory also fails to examine how patients are released from treatment.

In summary, Horwitz (2002a) argued that being labeled mentally ill required two elements: 1) incomprehensibility of actions and 2) social distance between authority figures and deviants. Furthermore, Horwitz (2002a) argued that social structure determines how people engage in treatment. Less social control is exerted on mentally ill people when societies are cohesive, non-stratified, and culturally homogeneous. However, when social structure shifts toward the individual, society increasingly uses exclusion, suggesting the dispersion of treatment. Finally, he argued that therapy and medication are the principal types of social control exerted in contemporary society, with the social distance between the therapist and patient influencing the use of involuntary or voluntary types of treatment.

Mental illness career over the life course

Goffman (1961) addressed the mental patient's career within the mental institution. In contrast, Aneshensel (1999) presents a model of the mental illness career over the life course. Her model conceptualizes mental illness in persons as feeling, thinking, and acting badly that then transition into illness onset. Illness onset is the "social discovery of the condition, which is essentially a matter of diagnosis" (592). The career's final stages are help seeking, remission and recovery, and possibly relapse. This model traces the mental illness career over a person's life course.

The model's first stage describes the beginning of the mental illness career. In this stage, the model conceptualizes mental illness as feeling, thinking and acting badly. The career's beginning is the first "transition from some existing state of normality to a new

state of distress…normality usually means deviations from societal standards, however, culturally idiosyncratic. This meaning is paramount in the "social response model"… and the labeling perspective…A second meaning, one more apparent in the medical model and the psychiatric approach…is deviation from what is usual for the individual. This meaning is centered within the person, not anchored to societal points of reference" (Aneshensel 1999: 590). This transition indicates a persons' movement from an ordinary status to a distressed status. Moreover, this change is frequently preceded by stressful events and limited resources for coping.

Illness onset, the model's second stage is where treatment is initiated. Illness onset is the social process leading to the understanding that something is disordered and that a person suffers from mental illness. The diagnosis process, social in nature, includes "the ways in which people, organizations, and institutions determine that there is a disease or a condition" (Aneshensel 1999: 592). At this point, the model presents three differing career paths: 1) Illness onset leads to more interaction with formal mechanisms (i.e., professionals, organizations, and institutions) for dealing with mental illness, 2) The person suffers symptoms outside the traditional mechanisms designed to treat mental illness; however, the symptoms may resolve themselves, and 3) The person suffering symptoms outside traditional mechanisms may not resolve problems over time and the symptoms become a source of chronic impairment. Illness onset concerns others' recognition that the individual's behaviors, thoughts, and/or feelings have deviated from what is normal and appropriate. This movement along the career path is driven by the social labeling process and does not originate with the individual but can co-occur with any symptoms (Aneshensel 1999).

The third stage explains why treatment occurs. This typically involves formal mechanisms (i.e., professionals, organizations, and institutions) that provide treatments to people with mental illness and resocializes them into patients. However, this process can involve other methods (i.e., spiritual and nontraditional). Help seeking is a social process that can be initiated either by individuals or agents such as police and/or family members. The persistence and intensity (i.e., incidence and prevalence of disorder) of the disorder as well as sociodemographic factors and social networks influence the career path for people with mental illness. Individuals who voluntarily seek treatment have a different career than those who are coerced into treatment. Here, a diagnosis allows those with mental illness to view their symptoms as treatable; however, it also means they must accept a devalued label (Aneshensel 1999).

The final stages of remission, recovery, and relapse consider the post-patient phase of mental illness, and extend further than other models of the mental illness career. First, symptom remission involves treatment effectiveness for the individual's illness type and severity. Second, recovery involves alleviation of symptoms. Finally, relapse deals with chronicity and symptoms that reappear and initiates the help seeking process again.

Aneshensel's (1999) model conceptualizes the treatment process, covering both voluntary and involuntary paths into treatment. Differences between Goffman (1961) and Aneshensel (1999) are located within the context of their theoretical frameworks. Aneshensel's (1999) career model is more inclusive than Goffman's (1961) theory. For example, Goffman's (1961) moral career applied only to institutionalized patients, whereas Aneshensel's (1999) career model applies to mentally ill individuals over their

life course. Additionally, Aneshensel's (1999) model incorporates pre-patient, patient, and post-patient phases of treatment. Goffman (1961) focused on the career within the organization, whereas Aneshensel's (1999) career model describes the career regardless of the organizational form. Although Aneshensel's (1999) theory deals with mental illness careers changing over time, one limitation is its neglects of the organizational form where treatment occurs and how organizational change may affect treatment.

In summary, Aneshensel (1999) argues that the mental illness career entails four stages. The first stage originates when an individual begins thinking, feeling, and acting badly. The second stage, illness onset, is the diagnosis process that leads to the understanding that something is wrong and the individual is suffering from a mental illness. Three possible outcomes include: 1) more interaction with formal mechanisms of treatment; 2) problems resolve themselves; and/or 3) unresolved problems become a source of chronic impairment. In the third stage, if the individual suffering receives help through formal or informal mechanisms, it can be the result of voluntary or involuntary treatment. The final stage, treatment engagement, ends with remission and recovery but can restart if a patient relapses.

In conclusion, theories about treatments for mental illness typically omit organizational change and organizational effects on individual outcomes. Although some theories account for temporal patterns in mental illness care, they neglect macro-level and mezzo-level factors on individual outcomes. However, other theories account for either macro-level or intermediate-level structures but neglect temporal changes. Although Horwitz (2002a) discusses how temporal changes in macro-level social structures affect treatment, he ignores mezzo-level mechanisms that achieve these outcomes.

Subsequently, I assert that omission of temporal changes and various levels of analysis limit the applicability of these theories to the mental illness career.

Neoinstitutional Theory

After Goffman's (1961) work on *Asylums*, theories about people with mental illness and their careers have neglected to situate individuals with mental illness within specific treatment contexts. Contemporary theorists discuss the relationship between professionals and individuals with mental illness and how mental illness careers change over time; however, there is a lack of organizational context. Most notably absent from current theories about mental illness and treatment is the role that organizational forms and behavior play in treatment. Since Goffman's analysis of the organization and its effect on people with mental illness (i.e., total institution), the organizational context of treatment has changed. Treatment today is dispersed throughout numerous organizational forms. Subsequently, I propose any understanding of mental illness and mental illness treatment careers requires a better understanding of the context surrounding the conceptualization and treatment of mental illness. New developments in organizational theory, specifically neoinstitutional theory, help to explain how the institutional environment influences organizational forms and behaviors.

Neoinstitutional theory provides an analytical framework for examining the context surrounding the conceptualization and treatment of mental illness. Figure 1 demonstrates how neoinstitutional theory explains changes in organizational forms and behaviors. This theory starts with three institutional elements: regulative, normative, and cultural-cognitive that generates three distinct isomorphic forces: coercive, normative and mimetic. These isomorphic forces generate institutional components, which affect

organizational fields along with the isomorphic forces. Organizational forms and behaviors are then influenced within organizational fields.

Theorists such as Max Weber argued that competition and efficiency were important mechanisms that explain institutional structure and change (DiMaggio and Powell 1991). In contrast, Meyer and Rowan (1991) argue in contemporary societies that certain components of formal structures are rationalized and fixed as myths. The term myth signifies a common understanding about social reality and legitimizes institutional traditions as the proper way to function. Myths guide, and can take the form of, professional requirements, organizational programs, technologies, prescribed methods, and standards for organizing behavior. When an organization structures itself to follow prescribed myths in an institution, the organization provides reassurances in the form of institutionalized rules. These institutionalized rules bestow legitimacy on the organization and shield it from failure regardless of the organization's efficiency (Meyer and Rowan 1991). For example, when a mental health organization structures itself around the current conceptualization of mental illness and provides the approved treatments to patients, it does not matter if the treatment outcomes are successful, what matters is that the organization is structured according to the contemporary myths that regulators and professionals deem legitimate.

Institutional Elements

Neoinstitutional theory identifies important elements that make up institutions. The first factor explained by neoinstitutional theory within the institutional environment includes three institutional elements. These include the regulative, normative, and cultural-cognitive elements (Figure 1). According to Scott (2008) "*institutions are*

comprised of regulative, normative and cultural-cognitive elements that, together with

associated activities and resources, provide stability and meaning to social life" (48).

Scott (2008) argues that the regulative institutional element is, "a stable system of

rules, whether formal or informal, backed by surveillance and sanctioning power that is

accompanied by feelings of fear/guilt or innocence/incorruptibility…" (54), and is

designed to constrain and standardize behavior. For the mental health sector there are two

related yet independent sets of rules that are backed by sanctioning power. These are the

policies designed and implemented to provide mental health treatment services, and, the

legal understandings about when treatment should begin and end. These policies and laws

are designed to provide a formal justification of when treatment should begin, who

should receive treatment, what should be provided, and when treatment should end.

The normative element, according to Scott (2008), entails "rules that introduce a

prescriptive, evaluative, and obligatory dimension to social life" (54). This includes both

values and norms. The values component of the normative institutional element consists

of conceptions about what is desirable and the standards for comparison. The norms

component of the normative element prescribes how things should function. The

normative element of the mental health sector can be observed in a number of activities.

For example, the types of treatment used are good indicators of the methods seen as

legitimate within the mental health sector. Moreover treatment justifications are good

indicators of the desirability for various mental health treatments. Finally, because certain

methods of treatment can be attached to an organizational form, the treatment location is

an important indicator of the desirability and methods of treatment. Together treatment

philosophies, practices, and locations demonstrate the prescriptive, evaluative, and obligatory dimensions to the mental health sector.

The cultural-cognitive element includes "the shared conceptions that constitute the nature of social reality and the frames through which meaning is made" (Scott 2008: 57). Neoinstitutional theory emphasizes the fundamental role of the collectively mediated creation of widespread frameworks of meaning. Cognitive frameworks are used to decide whether information is important, how it is stored, retrieved, structured, and interpreted and thus influences an actor's appraisals, decisions, and conclusions (Scott 2008). The cultural-cognitive element "stresses the central role played by the socially mediated construction of a common frame-work of meaning" (Scott 2008: 59). The cultural-cognitive element of the mental health sector is expressed in two distinct yet related ways. The first conceptualizes mental illness asking how is mental illness understood within the mental health sector? The second asks what patient characteristics of mental illness are important for treatment? For example, are patients with severe symptoms more likely to be treated than patients with personal or emotional problems? Together the conceptualization of mental illness and the important characteristics for treatment indicate the cultural-cognitive institutional element.

Collectively, these elements make up institutions but have differing sources of legitimacy. The differing sources of legitimacy point to independent origins of each element. The basis of legitimacy for the regulatory element "is on conformity to rules: Legitimate organizations are those established by and operating in accordance with relevant legal or quasilegal requirements." (Scott 2008: 61). For example, in order to obtain reimbursement from federal programs strict adherence to rules and regulations are

required otherwise denial of payment, investigation, and/or criminal penalties may be imposed. The basis of legitimacy for the normative element comes from a "deeper, moral base for assessing legitimacy. Normative controls are much more likely to be internalized than are regulative controls, and the incentives for conformity are hence likely to include intrinsic as well as extrinsic rewards" (Scott 2008: 61). Providing a particular type of treatment for a particular type of disorder, for example, may be normative. If violated organizations can lose accreditation and/or practitioners may be stopped from providing services. However, this violation may not rise to the level of an illegal act. Finally, the basis of legitimacy for the cultural-cognitive element "comes from conforming to a common definition of the situation, frame of reference, or a recognizable role, or structural template. To adopt an orthodox structure or identity in order to relate to a specific situation is to seek the legitimacy that comes from cognitive consistency. The cultural-cognitive mode is the "deepest" level because it rests on preconscious, taken-for-granted understandings" (Scott 2008: 61). For example, sharing similar understandings of the etiology of mental illness leads to similar interpretations about how they are expressed. These institutional elements, derived from their autonomous sources of legitimacy, both independently and combined, work to stabilize and change the organizational fields within the institutional environment (Scott 2008).

Isomorphic Forces

The second factor includes three isomorphic forces within the institutional environment and is generated by the three institutional elements. The three isomorphic forces are coercive, normative, and mimetic (Figure 1) and produce conformity in organizational forms and behaviors within the organizational fields. Neoinstitutional

theory argues that organizational similarities in form and behavior are a product of conformity pressures, are independent of competition and efficiency, and are exerted by the institutional environment (DiMaggio and Powell 1991). DiMaggio and Powell (1991) argue that in the beginning, organizational fields exhibit considerable diversity in organizational form and behavior. However, after a field is established it tends to standardize organizational forms and behaviors. For example, as innovation is adopted, the field reaches a point where legitimacy supersedes efficiency. In short, organizations sacrifice efficiency to obtain legitimacy. Neoinstitutional theory also argues that organizational forms and behaviors occur because of a need for conformity within a field. This conformity takes place because of the three isomorphic processes. DiMaggio and Powell (1991) assert isomorphism is a process that creates organizational similarity in forms and behavior when facing similar environmental conditions. Isomorphic forces, like institutional elements, are "ideal types" and typically co-occur. However, each mechanism is produced from different circumstances and each produces different effects on organizational fields (DiMaggio and Powell 1983). Scott (2008) argues that these isomorphic forces are associated with different institutional elements. Coercive isomorphism is associated with the regulative element, mimetic isomorphism with the cultural-cognitive element, and normative isomorphism with the normative element of the institution.

Coercive isomorphism refers to powerful organizations' ability to influence an organization's form and behavior through both official and unofficial demands within organizational fields (DiMaggio and Powell 1983). For instance, the government can influence an organization through regulation (i.e., billable services allowed by Medicaid)

or by withholding monies (i.e., if an organization does not follow the federal guidelines for implementation of Medicaid, the federal government can withhold reimbursement). Additionally private organizations can dictate the terms of participation in a field to other organizations. For example, managed care practices—a group of practices and policies intended to reduce healthcare costs—run by private companies can implement capitation, which is a type of fixed payment. This capitation is a predetermined rate per person for a range of medical services. These practices require healthcare providers to curb expenses or risk financial failure, which undermines treatment efficacy for mental health organizations (Mechanic 2008; Wells et al. 1995). Moreover, organizations in the mental health field with the power to implement coercive managed care practices can structure how other organizations that provide services behave.

Normative isomorphism refers to what organizational practices that reflect professional or societal ideas should be (i.e., what is "natural"). This process entails a united effort to delineate both the circumstances and methods involved in a profession. This is done in order to produce a cognitive framework, gate-keep, and legitimate a profession and subsequently provides occupational autonomy (DiMaggio and Powell 1983). For example, the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) (Dowdall 1996: 28) advocated for the use of the asylum to address social needs and concerns in the mid-nineteenth century. Based on psychiatric theory, AMSAII provided expertise to guide states' decisions regarding the timing and methods used to open and operate mental hospitals (Dowdall 1996). The profession advocated for and established circumstances and methods for treating mentally ill patients (state and county mental hospitals), which AMSAII staffed with their members

and produced a cognitive framework for what type of organizations and professionals would be used to treat those with mental illness.

Mimetic isomorphism refers to the process of mimicking or copying a successful organizational form. This typically occurs when there is a large amount of uncertainty among organizations, (i.e., organizational failures), or when organizations view other organizational forms or behaviors as more legitimate or successful. Uncertainty in technology, goals, and the environment increases the probability that organizations will copy successful organizational models (DiMaggio and Powell 1983). For example, since 1990, states have aggressively transferred their Medicaid populations into managed care plans in an effort to reduce costs.. Mimetic isomorphism can occur via a cascade of mimicking (Davis, Diekmann, and Tinsley 1994). For example, when states transitioned to managed-care plans, they typically exempted patients with chronic mental illness from these changes. However when these state policies went into effect many states channelled their disabled populations into managed care plans in order to constrain costs (Mechanic 2008).

Institutional Components

The third factor includes three institutional components within the institutional environment. The three institutional components entail institutional logics, governance structures, and institutional actors (Figure 1). The regulative, normative, and cultural-cognitive elements also interact with each other and produce change and stability within the mental health sector. According to Scott, Ruef, Mendel, and Caronna (2000) two of the components are produced by these interactions and one acts independently.

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Moreover, these components are a product of, and produce, isomorphic forces independent of the institutional elements that affect organizational fields.

Institutional logics are a combination of cultural-cognitive and normative elements. They symbolize the interaction of belief systems and related practices within the institutional environment. Institutional logics specify goals and values and "proper" methods for pursuing them. Thus, logics are important because they affect action within the institution (Scott et al. 2000). An example of institutional logics working within the mental health sector includes the cultural-cognitive element of the mental health sector (e.g., conceptualization of mental illness) interacting with the normative element (e.g., treatment practices) to form community-based care logic. For example, the psychosocial understanding of mental illness as a continuum interacts with what was understood to be the ideal type and location for treatment. This produces an institutional logic; the community is viewed as the best place to provide non-restrictive care to people with mental illness in an effort to prevent the mental illness from progressing further along the continuum.

Governance structures are comprised of normative and regulative elements, which supervise individual and organizational participation as well as coerce conformity. Thus, governance structures are primarily composed of normative and regulative elements (Scott et al. 2000). An example of governance structure can be found within the mental health sector. The regulative element (e.g., third-party payers) interacts with the normative element (e.g., treatment practices and locations) to change how and where treatments are provided. Both private and public third-party payers brought coercive pressure on medical practitioners to change treatment practices and locations because

they were seen as more cost-effective. Thus, the managed care governance structure is characterized by reducing costs by shifting treatments from social orientations toward medical orientations and continuing the push for treatment in community organizations.

The final component of an institutional environment includes institutional actors. Institutional actors consist of both individuals and organizations and mirror the cultural-cognitive elements, enforce regulative elements, and implement normative elements. Individuals and organizations can function as agents and/or carriers. Agents may exert power to affect institutional change; carriers may recreate or reproduce institutionally defined structures, capabilities, and privileges. Moreover, actors' concerns are formed by their locations within the organizational fields. Actors attempt to have these concerns addressed within the governance structure (Scott et al. 2000). However, because there are numerous institutional actors (i.e., organizational and individual) with different locations throughout the mental health sector, they are not represented in Figure 1. These institutional actors play an important role in institutional functions and can act to create and recreate core definitions, perform normative functions, and enforce regulations that create stability or change within the mental health sector.

Organizational Field

The fourth factor affected by the institutional environment is the organizational field (Figure 1). Neoinstitutional theory views organizations as embedded within organizational fields and these fields as nested within larger institutions. Organizational fields are comprised of "those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resources and product consumers, regulatory

agencies, and other organizations that produce similar services or products" (DiMaggio and Powell 1983: 143).

The two organizational characteristics of the organizational field include organizational forms and organizational behaviors. Organizational forms consist of the types of structures that organizations take while organizational behaviors include the types of practices and procedures engaged in by organizations. When the institutional environment prescribes change organizational forms and behaviors are influenced. For example, when the mental health sector developed the new community-based care logic the new logic began to give primacy to outpatient organizational forms. Moreover, when the conception of mental illness changed from a discrete to a continuum model, established organizational forms such as state and county psychiatric hospitals began to behave differently by treating more nonpsychotic patients. This change in organizational behavior corresponded to the new conceptualization of mental illness.

The final part of the institutional environment model is the feedback loop and connects the organizational field to the institutional elements (Figure 1). Once new organizational forms and behaviors are established, this loop shows how the cultural-cognitive, normative, and regulative elements that guide institutional change and stability are altered. An example of this is the establishment of the outpatient organizational form during the institutional care phase of mental illness. Once this outpatient organizational form was legitimized this placed pressure on the institutional elements. This pressure led to changes in the mental health sector leading to the community-based care phase.

Figure 1. Institutional Environment and Its Affect on the Organizational Field

Institutional Environment			
Institutional Elements	**Isomorphic Forces**	**Institutional Components**	**Organizational Field**
Regulative Element	Coercive	Governance Structures	Organizational Form
Normative Element	Normative		
Cultural-Cognitive Element	Mimetic	Institutional Logics	Organizational Behavior
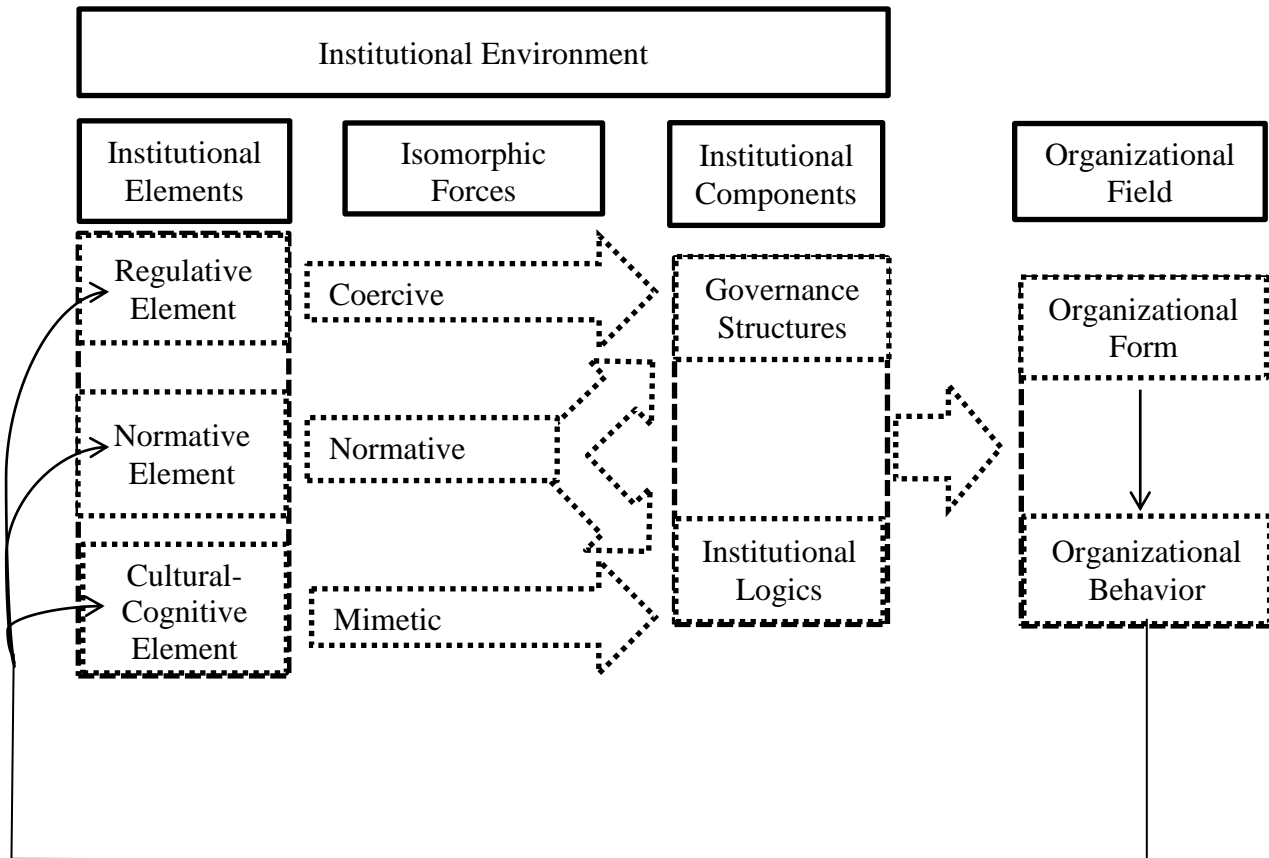
Neoinstitutional theory can provide new insights into the mental illness treatment career because the institutional environment (i.e., mental health treatment sector) influences and is influenced by institutional factors, organizational fields, and organizations and people with mental disorders who receive services. These theoretical developments provide an analytical framework for reexamining past and present literature regarding treatment engagement and mental illness careers. Neoinstitutional theory explains the role institutional environments play on organizational fields, which affects organizational form and behavior within the field. This theory argues that, once established, organizational forms and behaviors occur because isomorphic processes drive the need for conformity that leads to a homogenizing effect on organizations (DiMaggio and Powell 1983).

The focus of this research is on one component of the health care institution, the mental health sector, composed of various institutional factors, organizational fields, and organizations that are affected by their environments. Past research (Belknap 1956; Goffman 1961; Stanton and Schwartz 1954; Rosenhan 1973) on mental illness careers has taken into account the organizational context of treatment however, contemporary literature ignores the role institutional environments and subsequent organizational changes have on mental illness careers (Aneshensel 1999; Horwitz 2002a; Scheff 1999). I argue that neoinstitutional theory can help explain how change in institutional environments and organizations affect how patients engage in treatment.

Organizational Ecology

Neoinstitutional theory explains how the institutional environment affects organizational forms and behavior through institutional elements, isomorphic forces, and

institutional components. Similarly, organizational ecology is an organizational theory that explains organizational change as a result of macro-level processes. However, organizational ecology uses population processes within organizational populations to explain how organizations change (Hanna and Freeman 1989).

Organizational ecology assumes that once an organizational form is created there is little to no change. This lack of change is the result of organizational inertia (Hanna and Freeman 1989). Inertial forces are presumed to be powerful enough that organizational forms seldom succeed in making strategic and structural changes in the face of environmental threats (Hanna and Freeman 1984: 149). Attempting to change increases death rates of established organizations and the selection process favors organizations whose structures are resistant to change. Therefore, "change among organizations largely occurs at the population, rather than at the individual level, and is the product of differential founding and mortality not of adaptation" (Dowdall 1996: 19).

Organizational ecology builds on the idea that changes in organizational populations are the result of population, not adaptive, processes. This theory does not suggest adaptation is irrelevant but rather that it is limited in its influence on organizational survival. Adaptation can occur when conditions within the environment permit or require it (Hanna and Freeman 1989).

Organizational ecology and neoinstitutional theories emphasize different mechanisms responsible for organizational change and stability. Neoinstitutional theory emphasizes how the institutional environment affects organizational fields and subsequent changes in organizational forms and behaviors. Conversely, organizational ecology emphasizes competition and selection as impetus for change and stability within

organizational populations. Additionally, the organizational field and population are considered different units of analysis. The organizational field is concerned with a community of organizations "that, in the aggregate, constitute a recognized area of institutional life…" (DiMaggio and Powell 1983: 143). Organizational ecology focuses on organizational populations (i.e., specific organizational forms) and their interactions with other organizational forms.

Moreover, organizational ecology has difficulty explaining important issues that are relevant to this research. The first issue organizational ecology has difficulty explaining is what Dowdall (1996) refers to as a "Maximalist Organization." State and county hospitals are examples of maximalist organizations in that they are characterized by existence outside of competitive and selective processes that generate change according to organizational ecology (Dowdall 1996). For example, despite state and county hospitals being effectively replaced by other organizational forms, there may have been decreases in the number of state hospitals but no large-scale die off. Dowdall (1996) argues capital and labor investments, maintenance costs, niche definition, and monopolies of publicly supported patients within a geographic area (23-24) lead to the development of maximalist organizations. Consequently, this removes these organizations from competitive processes, or at least extends the standard life cycle predicted by population ecology. The final issue organizational ecology has difficulty explaining includes how the institutional environment affects organizational fields. This is mainly because organizational ecology does not theorize about the organizational field.

As a result, I argue that neoinstitutional theory is a more appropriate framework for my analysis for two reasons: 1) there are organizational populations within the mental

health sector that appear to be removed from competitive and selective processes (i.e., maximalist) and 2) my analysis attempts to understand the institutional environment and its effect on organizational fields. These issues are vital to the goal of this research and are not addressed by organizational ecology. However, organizational ecology is a parallel macro-theoretical approach that could be used to explain how organizational populations evolve over time within the mental health sector. Moreover, given enough time, maximalist organizations may succumb to competitive and selective pressures. Consequently, given enough time this theory could provide a competing explanation for changes in the mental health sector.

Socio-political-economic and Historical Context

Just as the institutional environment and its history are important to the mental illness treatment career, so is the socio-political-economic and historical context within which a mental illness treatment career takes place. Scott (1986) argues that the historical context of the nation-state, within which the mental health sector exists, is significant to the mental health sector's form and operation. More specifically, mental health organizations are likely to be influenced by the larger systems within which they participate: institutional environments (i.e., mental health sector), state systems (i.e., structuring of state mental health services), and the nation-state (i.e., the country within which the organization exists). Similarly, Grob (1991) argued that without the United States' experiences with the Great Depression and World War II, the mental health sector might have remained relatively static in form and operation. That is, these historical events changed how social, political, and economic relationships were structured across institutional environments leading to a different socio-political-economic and historical

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context. The historical context is an environment generated by a nation-state's reactions to certain historical event(s), which transform social and/or political and/or economic arrangements affecting all or a majority of institutions operating within its boundaries. Thus, I argue that a nation-state's larger socio-political-economic and historical context shapes the institutional environment by providing broad justifications for institutional stasis or change. The next chapter briefly reviews the changes that have occurred in the mental health sector over the last century using neoinstitutional theory as a framework.

Chapter 2: The Change in Mental Health Treatment over Four Treatment Phases

Mental health treatment has gone through dramatic changes over the past 60 years. Scheid and Brown (2009) argue that as society's values and priorities for dealing with people with symptoms of mental disorder have changed, so too has the mental health system. Public perceptions about mental illness and people with symptoms can influence the political climate, how leaders enact legislation, fund services, and the regulation of existing laws (Scheid and Brown 2009). Scheid and Horwitz (1999) argue that care for people with symptoms of mental disorder has advanced through four treatment stages that exemplify changing societal ideals of treatment, professional logics (i.e., shared ideas and beliefs) that dictate specific forms of treatment, and economic concerns that enable or constrain treatment. These four stages include institutionalization, deinstitutionalization, community-based care, and managed care (378-379). In this review however, I focus on three phases of treatment: the institutional care phase, community-based care phase, and managed care phase. I argue that deinstitutionalization is not a treatment phase but rather a process that transitions the institutional care phase to the community-based care phase. In this dissertation I only refer to deinstitutionalization as said process.

It is useful at this point to provide an account from patients' perspectives about how they engage the mental health sector during different phases of treatment. This account provides a general idea about what patients experience during a particular phase. Because this is an "ideal type" account of the mental illness career, it does not imply that every person with symptoms of mental disorders undergo the same experiences. It is

however, an effort to provide a glimpse of patient engagement at three distinctly different treatment phases.

During the institutional care phase (≈1945-1965) patients who were treated typically suffered from one of two general types of disorders: psychotic or brain impairment. Treatment, tended to occur in state and county mental hospitals where patients were confined within a "total" institution that constituted their environment while hospitalized. Characteristically patients would enter treatment through coercive means and treatments consisted of physical acts directed toward patients (i.e., shock therapy, hydro-therapy, and/or lobotomy). Treatment began and ended at the discretion of a medical professional's judgment as to whether the patient was in need of, or would benefit from, treatment.

During the community-based care phase (≈1965-1985) patient characteristics changed to incorporate more patients with nonpsychotic disorders. Although serious and chronic cases were still treated in state and county hospitals, treatment began to be provided outside of hospitals and in the community. Community mental health organizations, free standing outpatient clinics, and general hospitals with psychiatric wards began to treat more and more people with nonpsychotic mental disorders. Patients with brain impairment disorders shifted their treatment career to nursing homes instead of state and county hospitals. Although medications were used as a form of treatment, talk therapy was considered the gold standard and was thought to provide the key to a healthy mental life. Involuntary treatment still occurred in inpatient hospitals but the justification changed from whether the patient needed treatment to whether the patient was a danger to

him or herself or others. When using outpatient organizations, patients entered and left treatment on their own accord or in collaboration with a practitioner or provider.

During the managed care phase (≈1985-2005) patient characteristics continued changing with nonpsychotic disorders increasing as a result of structural changes. State and county mental hospitals, although still in existence, were used more for the criminally insane than for the public, regardless of mental status. While community mental health centers, free-standing outpatient clinics, general hospitals, and nursing homes are still used to treat mental disorders ambulatory mental health treatment is increasingly provided by non-specialty practitioners. Moreover, medications are the dominant treatment method because of their perceived treatment and cost effectiveness compared to talk therapy. As a consequence of the treatment structure continuing to change, patients entered and left treatment voluntarily in non-specialty practices and outpatient organizational forms; however, inpatient treatment could be entered either involuntary or voluntary. The justification for commitment remained whether the patient was a danger to him or herself or others. Involuntary treatment was subjected to judicial review, subsequently these commitments were shorter lived than in previous treatment phases.

Because the goal of this research is to explain the variation in mental illness treatment careers among these distinct treatment phases over time, these accounts of what patients experienced during a specific treatment phase are an important reference point. These three accounts provide a basic idea about how patients enter treatment, what patients experience during a particular treatment phase, and how treatment ends. An important question is: how is it that treatment changed so radically over a sixty-year

period? In this chapter, I review what the literature presents about differing mental health treatment phases, assumptions underlying their implementation, and the environment of mental health treatment within the institutional care, community-based care, and managed care phases.

Institutional Care Phase

Before the 1800s few mental institutions existed, insanity was not considered a social problem, and the family and community were responsible for providing care. As a result, social policy regarding the treatment of mental illness was largely non-existent (Grob 1985). However, during the mid-19th century, both professionals and lay people began to think of insanity as the consequence of an advanced civilization; the way society was organized was thought to cause mental illness. Engaging in normative isomorphism (i.e., the process of a professional organization to delineate both the circumstances and methods involved in their profession.), the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) reified this perception of mental illness. AMSAII was significant in the creation and proliferation of the asylum (Grob 1985) and advocated for the use of the asylum to address social needs and concerns of the time. Moreover, AMSAII advocated for institutional treatment guided by psychiatric theory as a way to ameliorate this social problem—mental illness. AMSAII provided expertise to guide states' decisions regarding the timing and the method used to open mental hospitals (Dowdall 1996) and did this in order to define both the work environment and standard practices involved in their profession. For example, as the precursor to the American Psychiatric Association, AMSAII "adopted a series of propositions that codified in great detail the proper size, location, construction, organization, and governance of hospitals"

(Grob 1985: 642). These actions produced an institutional logic that dictated the type of organization, profession, and treatment considered legitimate to help people with mental illness.

Mental institutions were seen as places that cured individuals by removing them from the stresses and aggravations of daily life. Removing persons from daily life and placing them in the mental institution was known as the moral treatment; separated from the community patients' daily routines were reformed through oversight (Rothman 2002). The moral treatment was supposed to occur in milieus where the ideal treatments included compassion, individualized care, therapeutic work, and religious practice (Grob 1985). Thus, mental institutions were thought of as enlightened and progressive solutions to mental illness (Grob 2000). Institutional actors like Dorthea Dix provided influential leadership by catalyzing the institutionalization process (Dowdall 1996). In an example of mimetic isomorphism, states began to copy the "successful" organizational model of the asylum. For example, in 1820 only one state had an asylum, however, by the 1860s, after being legitimated almost all states had one or more state mental hospitals (Grob 1985: 640). By 1948 all 48 states had mental institutions (Deustch 1973). Mental institutions were developed to humanely treat patients who would benefit from acute treatment and/or custodial care (Grob 2000). Custodial care provided patients with daily needs but not therapy. The successful Worcester State (Massachusetts) Asylum served as a template including both therapy and custodial care (Dowdall 1996).

Funding and policy were other factors that affected institutionalization (Grob 1985; Grob 2000). An important determinant for institutionalization–where mental institutions were the organizational form used to treat people with mental disorders–was

how the state funded treatment (Grob 2000). Between the 1830s and the 1880s, there

were relatively few long-term cases of mental illness in state asylums. The mental health

system divided responsibilities between communities and states. Almshouses were

typically run and used by the community to care for people with mental illness. However,

if a community did send someone to a state institution, that community would be required

to reimburse the state. Laws typically mandated hospitalization only for people who were

mentally ill and dangerous to others. People thought to benefit from institutionalization

could be committed. However, this was at the discretion of local officials, or, determined

by whether a patient's family was willing and able to pay for treatment. Moreover, no

one assumed that state institutions would care for every case of mental illness. Until the

1890s, divided fiscal responsibilities between local communities and states were

responsible for few long-term cases in the asylums. The majority of people with mental

disorders, however, lived in the community or almshouses (Grob 2000).

This treatment system, however, changed as states enacted legislation that

relieved local communities of their fiduciary responsibility. Many experts and policy

makers believed that local care, although less expensive, exacerbated chronic problems.

Coupled with this assumption was the belief that institutionalization would be cheaper in

the long run (even though it was initially more expensive) because it would increase the

probability of recovery and provide better care for people with mental illness (Grob 1985;

2000). This centralization of care began the institutionalization process where asylums

were the central organization used for mental health treatment (Dowdall 1996; 1999). In

an example of coercive (i.e., powerful organizations' ability to influence other

organizations' form and behavior) and mimetic (i.e., the process of mimicking or copying

a successful organizational form) isomorphism, New York and Massachusetts led the

policy change that relieved local communities of their fiscal responsibilities (Grob 2000).

Communities and public officials saw an opportunity to shift fiscal responsibility to the

state. Going beyond the intent of the law, local governments and officials redefined

senility in psychiatric terms and transferred old people from almshouses to state

hospitals. This was reflected in the decline in persons with mental illness over the age of

60 in almshouses from 24.3 percent to 5.6 percent from 1880 to 1923 respectively (Grob

2000). This redefinition of senility changed the role of state asylums with an increase in

long-term care. Mental institutions were now used to warehouse people and provided

little to no treatment. In 1904, 39.2 percent of patients were hospitalized for five or more

years; by 1910, that number was 52 percent. Moreover, old people consisted of one third

of all residents in state hospitals (Grob 2000).

The institutional phase saw dramatic changes in treatment for people with mental

illness. Normative, coercive, and mimetic isomorphic forces helped to institute and, later,

change the state hospital's role in treatment. AMSAII was an important factor in the

creation and proliferation of the asylum (Grob 1985) and led to normative isomorphism.

Initially, mental institutions were established to provide patients with "moral treatment".

States began to copy the organizational model of the asylum after it was legitimated.

However, an example of both coercive and mimetic isomorphism occurred when states

enacted legislation that relieved local communities of their financial obligations to pay

for treatment. This had the effect of changing treatment from moral to custodial

treatment. Taken together, these influences led to widespread institutionalization of

mental patients where state mental hospitals were the main organizational form used to

treat people with mental disorders (Dowdall 1996). Treatment in this organizational form was not seriously challenged until the end of World War II.

Institutional Care Problems

Due to political and demographic changes discussed above, state hospitals lost their reformatory design and transitioned into places of custody. Advocates of mental institutions did not design moral treatment for the chronic mentally ill. The number of patients increased in conjunction with the size of institutions (Rothman 2002). By the 1950s, state mental hospitals housed over 500,000 people in the United States (Dowdall 1999). The first indication of problems within institutions came from conscientious objectors of WWII who were assigned to mental hospitals during the war. Following these stories were reports from the media and former patients about their experiences in mental hospitals. These groups began to allege mistreatment and poor quality of care in mental hospitals (Dowdall 1999; Grob 2000).

After World War II, news stories and testimonials that shocked the public began to emerge from state mental hospitals. These stories pointed to problems such as crowding, deterioration of physical structures, poorly trained staff, therapeutic failures, and dehumanization of patients (Dowdall 1999). Coupled with these stories research demonstrated the dehumanizing effects of mental hospitals (Goffman 1961). The public and the mental health profession became disillusioned because not only did mental hospitals fail to live up to earlier promises as a solution for mental illness, (Grob and Goldman, 2006) they were sometimes harmful to patients (Dowdall 1999). Subsequently, treatment philosophy and the pattern of hospitalization as a form of treatment changed to

one where mentally ill people could benefit from already established relationships in the community, rather than isolating them in state hospitals (Grob and Goldman, 2006).

Sociologists also became disillusioned with mental institutions and became an important force undermining them (Dowdall 1999). Goffman's (1961) seminal analysis accused state hospitals of further aggravating mental problems (Dowdall 1999). Goffman's research focused on how mental institutions affected patients' lives and further aggravated their symptoms. Total institutions stripped people of their civilian identity and provided them with an official means to rebuild their identity. This stripped and rebuilt identity did not last after release. What lasted was the label of being a former mental patient (Smith 2006).

Goffman's (1961) work helped justify the deinstitutionalization process and had enormous implications for people with mental disorders (Dowdall 1999). "Goffman's (1961) analysis of these institutions…led to the recognition that inpatient care could stigmatize individuals and prevent their return to society. Furthermore, state hospitals provided little therapy or treatment; instead, they served custodial functions" (Scheid and Horwitz 1999: 380). The problems created and exacerbated by large psychiatric hospitals were supposed to be resolved by deinstitutionalization.

Community-Based Care

Deinstitutionalization transferred the location of care from state hospitals to communities. Multiple factors led to this process (Cook and Wright 1995) such as the use of psychotropic medication, new treatment philosophies, legal activists (Grob and Goldman, 2006) who facilitated court rulings that changed commitment standards (Scheid and Brown 2009), and policy changes, which subsidized alternatives to

traditional forms of treatment (Lerman 1982). Deinstitutionalization had two goals: 1) to empty state hospitals and 2) treat patients in a network of community-based institutions (Gronfein 1985). Deinstitutionalization has had a profound effect on people with symptoms of mental disorder (Cook and Wright 1995) by both making it easier for people with emotional problems to access treatment, and, undermining continuity of long-term care for the severely mentally ill (Mechanic 2004), Isomorphic forces were responsible for changes in prevailing treatment practices and patterns. Normative isomorphic pressures, in the form of professionally determined logics and a new treatment philosophy, changed to emphasize psychosocial and psychoanalytic models which conceptualized mental disorders as being caused by life experiences and environmental factors (Grob 2000). Additionally, psychotropic medications were a new technological development affecting treatment philosophies. The introduction of psychotropic drugs in the early 1950s helped to increase release rates and decrease length of stay. In theory, psychotropic drugs would enable those who were chronically mentally ill to participate in therapy (Grob and Goldman, 2006). Moreover, psychotropic drugs gave a false sense of confidence to mental health professionals, the public, bureaucrats, and family members that these drugs would help patients escape state hospitals and allow them to move back into the community (Mechanic 2008).

Research suggests that the introduction of psychotropic medications did not accelerate discharge rates after immediately after 1955 (Gronfein 1985). What these medications did was provide support to the emergence of a new community-based treatment philosophy from policy makers regarding mental health treatment. It is unlikely that deinstitutionalization could have occurred to the extent that it did without these

psychotropic medications (Mechanic 2008). This normative isomorphic force: faith in a new treatment philosophy and medical science to alleviate the burden of disease, led to a belief in the emphasis of treatment in the community. With the combination of psychotropic medications and the psychosocial model of mental disorder, the belief that treatment could, and should, occur in the community developed. People with mental illness would be reintegrated back into society with therapy, humane treatment in hospitals, and local services (Mechanic 2008). In February 1963, President Kennedy argued for a new method that used new knowledge and drugs that would allow most people with mental illness to be treated in their own communities (Grob and Goldman, 2006).

In addition to new treatments, new federal policies served as a coercive isomorphic mechanism by providing revenue to create an infrastructure that subverted the state hospitals' roles in treatment. These policies were championed by the Group for the Advancement of Psychiatry, which was the progressive arm of the American Psychiatric Association (Kirk 1999). Their first step was to draft an act that established a federal mental health institute. In 1946, the National Mental Health Act made grants to states to create clinics (e.g., outpatient facilities) and treatment centers (e.g., short-term inpatient facilities) and launched the National Institute of Mental Health (NIMH). This agency advocated for a community-based treatment philosophy and new organizational forms to replace state mental hospitals. This was accomplished by grants that promoted the idea that states could use these funds for alternatives to their mental hospitals (Grob and Goldman, 2006). Robert H. Felix, the first director of NIMH, had a covert plan to undermine and destroy state mental hospitals (Kirk 1999).

Champions of the community-based model of care lobbied congress to pass the Mental Health Studies Act in 1955. This piece of legislation resulted in the Joint Commission on Mental Illness and Health (JCMIH) report: *Action for Mental Health* published in 1961 (Kirk 1999). This report embodied a community-based treatment philosophy and argued for expanding therapeutic services, early interventions, broad partnerships of professionals, and grass root organizations in order to provide treatments in the community. According to the report, community mental health clinics would be the main tool for reducing hospitalization (Grob and Goldman, 2006). Together, this report and the NIMH championed the next coercive mechanism, The Mental Retardation and Community Mental Health Centers Construction Act. Passed in 1963, this act provided federal monies for construction and staffing of Community Mental Health Centers (CMHCs). CMHCs were community-based institutions that would replace state mental hospitals and were designed to prevent and/or treat mental illness through community-oriented preventive, diagnostic, treatment, and rehabilitation services (Grob and Goldman, 2006). However, these two policies were small steps in deinstitutionalization.

The next coercive isomorphic force that initiated a change in treatment was the Federal government's funding of programs to keep mentally ill people economically independent and in the community (Dowdall 1999; Mechanic 2008; Scheid and Brown 2009). In 1965 Medicaid, and in the 1970s Supplemental Security Income (SSI) and the expansion of Social Security Disability Insurance (SSDI), (both disability programs run by Social Security) were enacted (Dowdall 1999; Mechanic 2008). These policies did as much as, or more than, other policies to facilitate deinstitutionalization by providing a steady source of income and access to mental health care to patients while undermining

state hospitals' roles in treatment (Dowdall 1999). Initially the biggest shift included patients from state hospitals to nursing homes. Shifting patients from one institution to another—transinstitutionalization—was a major aspect of deinstitutionalization (Mechanic 2008).

In addition to new policies other coercive forces occurred. Civil liberties of people with mental illness were beginning to be established through court cases. Social scientists and lawyers argued for keeping patients in the community (Mechanic 2008) based on empirical evidence of the harmful consequences of both long-term and involuntary hospitalization (Goffman 1961). Involuntary hospitalization became difficult unless patients were deemed a threat to themselves or someone else. These civil liberties supported beliefs that emphasized personal freedoms (Mechanic 2008). Additionally, legal rulings (i.e., *Covington v. Harris* (617 F. 419 [1969]) and *Wyatt v. Stickney* (344 F. Supp. 373 [1972])) that restrained the use of involuntary hospitalization also mandated adequate and effective treatment in state mental hospitals. This was accomplished through requiring humane psychological and physical environments and enough staff to provide treatment plans. These legal changes also facilitated deinstitutionalization by increasing states' costs of providing care and creating fiscal burdens (Teed and Scileppi 2006). Along with reinstating civil liberties to those with mental illness, the courts ruled that the Federal Fair Labor Standards Act covered patients who worked in institutions entitling them to minimum wage. This placed additional financial burdens on states and changed vocational and occupational rehabilitation programs by making certain programs cost prohibitive (Teed and Scileppi 2006).

Together new treatment philosophies, policies, medical treatments, and civil liberties worked to transform the location of mental health care from large state and county mental hospitals to the community. During the 1960s, psychiatry was concerned with treating communities and groups using treatment programs consisting of consultation, in-service training, and public education. The community mental health philosophy was compatible with the community-based ideology that emphasized empowering people and small groups to take part in decisions that affected their lives (Grob 1991a). This movement was linked to larger movements—civil rights, education, and voting rights—attempting to include disenfranchised segments of the population in this country (Kenig, 1992).

Moreover, experts and policy makers assumed that federal leadership and funding combined with community organizations would work together to provide more useful and efficient social and medical policies (Grob 1991a). Community Mental Health Centers (CMHCs) were supposed to replace the state mental hospitals as the center of treatment and prevent and/or relieve mental illness through community oriented preventative, diagnostic, treatment, and rehabilitation services (Grob and Goldman, 2006).

CMHCs incorporated two organizational forms to provide services to mentally ill people: inpatient and outpatient. However, free-standing inpatient and outpatient organizations independent of CMHCs also existed. The new inpatient organizational form typically occurred in a general hospital and was designed to stabilize people going through acute crises and release them back into the community within a relatively short time span. Outpatient facilities increased in number and were used by new types of

patients who did not fit the severe or chronic mental illness category. This new type of patient who previously had no access to such services increased the population of those who sought treatment for their mental illness. Halfway houses were also used, although to a lesser extent. Halfway houses helped the transition from hospital to community, provided permanent placements for patients released from the hospital and requiring assistance to live independently, supplemented hospitalization, and shortened the length of stay in the hospital. While private inpatient units were also used, they were not used as permanent residences (Grob 1991a). Other organizations such as nursing homes and boarding homes were destinations for people with mental illness in the community (Brown 1979).

CMHCs were designed to address community problems with preventative and recovery treatment methods and to develop and hone treatment modalities. Unfortunately, the mission required of the CMHCs was broad and ambiguous (Grob 1991a). CMHCs were obligated to provide five services for patients to be eligible for federal funding: 1) inpatient services, 2) outpatient services, 3) partial hospitalization services, 4) twenty-four-hour emergency services, and 5) consultation; within at least one of the first three services, the fourth and fifth were required (Grob 1991a: 245). These five services later evolved into ten services (Grusky et al. 1985). However, with no consensus on how to define the term community, it was defined as an area population ranging between 75,000 to 200,000 people. This range represented a compromise between the high costs related to more units serving smaller numbers and the administrative problems of fewer units serving larger numbers (Grob 1991a).

Ambiguity about the role of CMHCs had significant implications in the way centers functioned. Different professionals—psychiatrists, psychologists, and social workers—defined mental illness, mental health, and community mental health differently. Some defined community mental health to mean care and treatment would occur in the community. Others defined community mental health as interventions designed to prevent mental illness. Finally, some defined community mental health as changing environmental conditions that promoted mental illness. These differences led to different types of organizations and organizational goals (Grob 1991a: 251).

The National Institute of Mental Health (NIMH) attempted to address this ambiguity in 1977 by developing the Community Support Program (CSP). CSP was designed to assist states in planning and implementing comprehensive, community-based services for people with mental illness. This program represented a shift in NIMH's philosophy from focusing on the deleterious effects of institutionalization to the unintended consequences of deinstitutionalization. The attempt was to develop accountability at the local level and to hold organizations accountable for area programs and services (Grusky et al. 1985).

CMHCs also lacked clarity about the type of patients they should serve leading to ambiguity about appropriate treatment methods. The continuum, or psychosocial understanding of mental illness, supported the approach of intervention by identifying individuals in trouble and providing treatment quickly. However, because this understanding viewed less serious types of mental illness as problematic as serious types, individuals with chronic mental illness were forced to compete for services with those whose problems were less severe. Addressing the numerous problems of people with

serious mental illness was not easy because these problems are difficult to manage, require comprehensive care, and do not respond well to counseling. Moreover CMHCs favored individual counseling, which worked well for those who had less serious problems, were middle-class and educated. However, the majority of patients were uneducated and inarticulate. The counseling method was not suited for the majority of patients and even if it had been, there were not enough counselors to provide treatment (Grob 1991a).

The community mental health system was unprepared without a clear understanding of the new challenges posed by deinstitutionalization (Kenig, 1992; Rosenberg and Rosenberg 2006). Developed to replace, or as an alternative to, state run hospitals CMHCs were not fulfilling the needs of the severely mentally ill. CMHCs were offering unproven preventive services and crisis counseling for predictable life problems (Grob 1991a). This movement to community-based care fragmented the treatment location. Unlike the institutional phase, where treatment was centralized at the state hospital, during the community-based care phase the numerous facilities used to treat mental illness had the effect of dispersing those with severe or chronic mental illness throughout the mental health care system (Grob 1991a).

Problems with Community-Based Care

Several assumptions motivated community-based care treatment philosophies spurring deinstitutionalization. The first, and arguably most important, included the notion that families and the public would welcome the severely mentally ill back into the community. Intertwined in this assumption were added assumptions that the severely mentally ill would have homes to go to, supportive environments, unimpeded treatments,

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support networks, and occupational opportunities (Grob and Goldman, 2006). These assumptions created problems for those with serious mental disorders. It was unrealistic to assume that the severely mentally ill could live in communities while receiving seamless treatment. This was because there were no basic support structures or housing (Grob and Goldman, 2006). Deinstitutionalization relegated those who were severely mentally ill with increased prospects of homelessness, discontinuity of care, and transinstitutionalization (Cook and Wright 1995).

After deinstitutionalization, homelessness became a major social problem. Because a large number of the homeless were mentally ill, many people saw deinstitutionalization as, at least partially, causal (Dowdall 1999). Homelessness is difficult to estimate, but between 33 and 50 percent of the homeless are estimated to be mentally ill and 22 to 57 percent of the homeless are estimated to be seriously mentally ill (Dowdall 1999).

In addition to homelessness, deinstitutionalization engendered a discontinuity of care. Even though state-run hospitals had problems, they provided a place of residence, a sense of community, and seamless care to the majority of those with serious mental illness (Dowdall 1999). While care in the community benefited a large number of people with mental illness, a large increase in for-profit mental heath care served to exclude those with serious mental illness from treatment. Beginning with deinstitutionalization, treatment dealt more with persons suffering from emotional problems forcing those with serious mental illness to compete for needed services (Grob 1991a; Grob and Goldman, 2006). After deinstitutionalization, care for people with serious mental illness became and currently is, less consistent (Dowdall 1999; Grob 1991a). For example,

hospitalization stays are shorter and treatment emphasizes outpatient services (Cook and Wright 1995).

Transinstitutionalization was a major consequence of deinstitutionalization resulting from both coercive and mimetic isomorphism. New policies enabled public and private organizations to save money by shifting patients to different treatment facilities. For example, by 1973 nursing home populations had doubled (Grob and Goldman, 2006) because patients were shifted from state hospitals (Mechanic 2008). Brown (1979) viewed deinstitutionalization as a series of shifts of care from institution to institution. Many people with mental illness ended up in prisons or jails instead of being hospitalized or treated in the community (Dowdall 1999).

The belief that mental institutions created and exacerbated mental illness was a driving force behind deinstitutionalization and community-based care (Dowdall 1999). Ironically however, the belief that being in the community exacerbated mental problems had played a central role in creating institutionalization in the first place (Grob 2000). Similarly, institutionalization a century earlier advocated for hospitalization of the mentally ill in order to protect patients from their families and communities (Rothman 2002) whereas the normative belief of community-based care advocated that patients would benefit from already established relationships in the family and community (Grob and Goldman, 2006).

Funding for mental health care tends to be driven by government policies (Scheid and Brown 2009). During the community-based care phase, states had financial incentives to shift care from state-run organizations to community and/or private organizations that were reimbursed by federal dollars (Lerman 1982; Mechanic 2008).

Just as local communities' abilities to transfer the financial burden to the state helped to fuel the institutionalization process (Grob 2000) deinstitutionalization was also helped by states' abilities to transfer the financial burden to the federal government (Brown 1979). Brown (1979) argued that the U.S. mental health policy since World War II was driven, in part, by financial crises attempting to pass responsibility from states to federal government. These coercive isomorphic forces occurred via a cascade of mimicking within the community-based care phase.

However, the problems of community-based care that forced change were not the result of homelessness, discontinuity of care, and/or transinstitutionalization, but rather of increasing third-party-payer costs and decreasing federal supports. Growing concern about the rising costs of health care in the 1980s led the federal government to decrease reimbursement and funding for various types of mental health services. Moreover, concerns among the private sector (insurance companies) regarding costs led to governance structures designed to control costs. This pushed psychiatric services further into the community (Mechanic 2007).

Managed Care

Managed care has profoundly shifted governance structures in the mental health sector. Managed care refers to "a variety of organizational and financial structures, processes, and strategies designed to monitor and influence treatment decisions so as to provide care in the most cost-effective way" (Mechanic 2008: 167). In the past, experts (who were usually doctors) decided what services to administer. These services were typically considered legitimate to insurers. Over the past 30 years, managed care companies, through Health Maintenance Organizations (HMOs) and utilization reviews,

have scrutinized expert recommendations for treatment. Scheid (2003) argues that managed care is a reaction to broader normative forces demanding technical rationality and efficiency. This coercive process differs from the traditional bureaucratic model and emphasizes a commodity model. Since the definition of efficiency consists of cost reductions, the commodity model requires changes in organizational structures in order to maximize profits; however, the traditional model argues efficiency is an outcome of organizational structures and rationalization (Scheid 2003).

Managed care practices vary (Mechanic 2008; Scheid and Brown 2009) and include four mechanisms: capitation, gatekeeping, utilization management, and incentives and risks (Mechanic 2008: 167). These four mechanisms are coercive forms of isomorphism that shape health care organizations and outcomes. These coercive mechanisms influence providers' treatment plans for their patients. Capitation is a predetermined rate per person for a range of services, or fixed payment. Capitation places mental health care providers at financial risk requiring them to curb expenses to prevent financial loss. Gatekeeping restricts access to specialists, hospitals, and procedures by requiring primary care physicians to provide referrals to patients seeking specialty services. Utilization management involves precertification, a process requiring permission before treating patients. In concurrent reviews a reviewer determines how long inpatient care can occur. Incentives and risks are used to encourage providers to keep costs down.Theses mechanisms were designed to reduce health care expenses and subsequently cost (Mechanic 2008; Wells et al. 1995).

Depending on the type of mental disorder a patient is diagnosed with, managed care plans vary as to their abilities to provide adequate treatments. Private versions of

these plans provide for common problems like depression and anxiety much better than psychosis. They thus provide mental health benefits suited to address less chronic types of problems while neglecting problems that require long-term resolutions especially severe and chronic mental disorders. Plans limit the number of in-patient hospital days and outpatient visits for individuals with mental disorders. Few plans provide appropriate treatments to persons with chronic or severe mental disorders (Mechanic 2008). As a result, people with serious forms of mental illness tend to be enrolled in Medicaid or other state-run programs. However, in the last two decades, states have aggressively transferred their Medicaid populations to managed care plans in the form of both coercive and mimetic isomorphism. Only 2.7 million Medicaid enrollees were in a managed care plan in 1991; in 2004, 27 million were enrolled. At the outset of the managed care phase, states exempted people with chronic mental illness from these changes but now many states channel their disabled populations into managed care plans (Mechanic 2008).

Like previous phases the managed care phase also saw changes in the mental illness career. In the 1990s, federal policy on mental health care changed. Treatment and rehabilitation efficacy became the foci paralleled by managed care as a strategy for dealing with health care costs. Managed care was significant because its coercive mechanisms were designed to control use and cost of treatment limiting the ability of mental health programs, organizations, and providers to deliver services (Grob and Goldman, 2006). As a result, people with serious mental illness were unable to receive appropriate treatments (Scheid and Brown 2009). This phase saw aggressive mimetic isomorphism through patient populations being transferred to programs in an effort to cut costs (Mechanic 2008). These isomorphic forces had important implications for people

with mental illness, and their treatments, both by weakening medical professionals'

authority and restricting insurance coverage for treatments.

Managed Care Problems

Managed care represents a profound systematic change in the institution of

healthcare. The impetus for managed care was a reduction in government funding for

public health and rising health care costs in the private sector (Scheid 2003). There has

been limited public opposition to managed mental health care, both in public and private

sectors. In two separate reviews of the literature, Hutchinson and Foster (2003) and

Mauery, Vaquerano, Sethi, Jee, and Chimento (2006) found that managed care tended to

improve access to mental health services, shift the composition of patients to less chronic

conditions, and reduce inpatient care. These findings support the premise that managed

care shifts treatment from mental hospitals to communities (Mechanic 2007) through

coercive isomorphic means.

Evaluation of managed mental health care is difficult because of the diversity of

programs and the trouble defining treatment effectiveness (Scheid and Brown 2009). In

general, managed care has made access to mental health services easier; however, people

with serious mental illness do not benefit to the extent that those with acute and personal

problems do (Mauery et al. 2006; Mechanic 2007). Managed care compels organizations

to use a commodity model, which undermines professionally determined logics to treat

people (Scheid 2003). To reduce costs, managed care replaces psychiatrists with mental

health personnel (e.g., social workers and nurses) (Mechanic 2007).

Moreover, managed care has changed the treatment logic for the severely

mentally ill. From the 1960s to the mid-1980s, community-based care emphasized both

coordinated and integrated services. The community-based logic favored social over medical care. The goal was to modify the person's ability to cope in the community and provide a continuum of care. Currently, the managed care logic, however, emphasizes medical treatment over re-socialization. The managed care logic represents a type of coercive isomorphism that has led to changes in both organizational forms and behaviors. Consequently, the quality of care, especially for those with chronic and serious mental illness, has been negatively affected (Scheid 2003).

The three phases of mental health treatment demonstrate a dynamic mental health care treatment sector. The forces leading to institutionalization during the 19th century involved professional medical organizations that defined the problem (mental illness) and provided the solution (the asylum) (Grob 1985). Subsequent to that, isomorphic forces began to homogenize the mental health care system until normative and coercive forces in the form of professionals and policy makers expanded the role of the asylum. Similar forces that had led to the institutional care phase contributed to deinstitutionalization and the emergence of the community based care phase. During deinstitutionalization, mental health professionals and the public redefined the institutional logic (institutional care) as the problem and provided the solution (community-based treatment). While this new institutional logic (community-based treatment) continues to be legitimate in the managed care phase healthcare providers have increasingly lost power.

Research has rarely investigated the mental illness career within a socio-political-economic and historical context. In other words, the literature fails to ask how the nation-states' overarching social, political, and economic logics over a particular time affect individuals' mental illness careers. Moreover, when changes in mental health

treatments are discussed, scholars have a tendency to emphasize the regulative and normative mechanisms of institutional change while neglecting cultural-cognitive conceptions. For example, typical discussions of deinstitutionalization focus on the creation of new policies (e.g., regulative element) and new treatments (e.g., normative element). Simultaneously, the conceptualization of mental illness (e.g., cultural-cognitive element) and the role it has played in changing the mental health sector is neglected. Additionally, professionals, organizational forms, and behaviors vary depending on the phase of treatment, which play an important role in mental illness careers. For example, the institutional phase's main organizational form was the state mental hospital, whereas multiple organizational forms were important to different patients during and after the community-based care phase. Individually and collectively these factors changed how mentally ill individuals experienced their mental illness careers.

Neoinstitutional theory looks at how institutional environments affect organizational fields and organizations. Given that each of the three mental health treatment phases uses different organizational forms and professionals, individual mental illness treatment careers vary. I use neoinstitutional theory to assess evidence of how mental illness careers differ based on these three different treatment phases. I argue neoinstitutional theory helps explain how institutional environments, organizational fields, and organizations change during each phase of treatment. I also argue neoinstitutional theory helps to explain how these larger environmental forces affect the careers of people with mental disorders.

Chapter 3: Methods

Historical Analysis

The purpose of this research is to demonstrate how patients' mental illness treatment careers are dependent on change and/or stability among differing levels of social structure. The method used to gather and analyze data is historical analysis. Historical analysis is both a descriptive and contextual method that uses process, structure, duration of phenomena, and interaction between process and structure to develop a contingent view of causality (Skocpol 1984). This research method uses primary and secondary sources as data. According to Tuchman (1994) primary sources are typically historical data (documents or traditions) drawn from the period the researcher is attempting to explain. Secondary sources are books and articles written by social scientists and historians about the specific topic or an aspect of the topic (Tuchman 1994).

Skocpol (1984) argues historical analyses are comprised of the following characteristics: They generate and address questions about social structure or processes that occur, but are typically conceptualized as static across time and space. Next, when addressing these structures and processes over time, temporal sequence becomes important in determining outcomes. Then, in order to discern consequences of unintended and intended actions, it is important to examine the relationship between actions and context. Finally, these studies call attention to "*particular* and *varying* features of specific kinds of social structures and patterns of change" (Skocpol 1984:1). This dissertation meets these requirements because it includes the following: First, it questions mental illness careers and the literature's assumption of stasis. Second, it examines changes over

time at the historical, institutional, organizational, and individual levels. Finally, it highlights the changing characteristics of the mental health sector and the organizations within the sector as well as their effects on individuals' mental illness careers (the outcome).

Reviewing the literature on the different phases of mental healthcare treatment shows that each phase of treatment has a unique institutional environment. Each institutional environment also shapes the types of organizations and professionals used to treat those with mental illness; this leads me to argue that changing the social structure alters the career of the mental patient. Four phases of mental healthcare treatment are identified: institutionalization, deinstitutionalization, community-based care, and managed care (Scheid and Horwitz 1999). However, in this analysis I categorize only three of the four treatment phases: institutional care , community-based care , and managed care. The first two phases, institutional and community-based care, are identified by dominant institutional logics attached to their particular phases of mental health treatment. The last phase, managed care, is connected to change in governance structure and currently guides mental health treatment.

Using institutional logics as a way of identifying the first two phases is somewhat different than how Scott et al. (2000) delineate their three "institutional era[s]" of health care (175). They use three distinct governance structures to identify the three institutional eras: association, state, and market models. The association model theorizes that certain interest groups such as AMSAII or the APA hold a monopoly status within an institution and employ normative influence over a number of actors. The state model theorizes that governmental agencies exercise control over an institution through coercive means.

Finally, the market model hypothesizes private parties compete in an effort to make a profit, and market competition produces conformity (Scott et al. 2000). However, this classification does not necessarily apply to the mental health sector because the first two phases fall under a state model governance structure. For example, the first treatment phase (institutional care 1945-1965) is a state mental health governance structure while the second phase (community-based care 1965-1985) is a federal-state mental health governance structure. As a result, I use the institutional care and community-based care logics to delineate the first two phases.

When examining the literature it is difficult to attribute an entirely separate phase to deinstitutionalization. Numerous isomorphic forces affected the deinstitutionalization process. However, this process was not an institutional logic or a new governance structure; it was a process that transitioned patients to different treatment locations. During the institutional phase the prevailing treatment location was the inpatient setting, which fit with the dominant institutional logic. During the community-based care phase, the prevailing treatment location included short-term inpatient settings and outpatient settings that also fit with its dominant institutional logic. It was the institutional logic of community-based care, then, that drove deinstitutionalization and not an independent logic generated by deinstitutionalization. In other words, I argue that deinstiutionalization was a *process* (not a phase) that transferred patients from large psychiatric hospitals to community-based organizations (emphasis mine). The last phase (managed care 1985-2005) in this analysis, however, is not represented by an institutional logic because it represents a new governance structure. This governance structure represents coercive elements affecting the normative elements within the mental health sector, all while

maintaining the community-based care logic. Because deinstitutionalization does not represent an institutional logic or governance structure, and was a method of replacing a particular institutional logic with another, it is not used to denote a specific treatment phase.

Finally, this dissertation provides evidence of how mental illness careers have changed depending on the treatment phase and changes in higher levels of social structure. Although abundant information about mental health treatment and the organizations used to treat people with mental illness exist, there is no clear understanding of how changes in macro level social structures affect intermediate levels of social structure and how this changes mental illness careers. Subsequently, a description of these social structures and mechanisms used to generate this change is required over the three treatment phases.

Gove (2004) provides a framework for studying mental illness careers that explains how patients engage in treatment. Treatment engagement is a process in which a person obtains treatment through either voluntary or involuntarily routes. Gove's (2004) framework can be used to integrate the mental illness career across different levels of social structure. Using a modified version of Gove's (2004) framework, seven research questions are used to describe how people with mental illness engage in treatment during the different phases: (1) what was the socio-political-economic and historical context of the nation-state during the time the mental illness career was being evaluated? That is, what is the nation-state's overarching social, political, economic, and historical logics of a particular time that would guide policy and affect an individual's mental illness career? (2) Who is considered mentally ill during different phases of treatment? (3) What patient

characteristics are important for treatment? (4) How are people with mental illness treated? (5) Where are people with mental illness treated? (6) What are the legal and administrative thresholds for treatment? (7) How are patients released from treatment? These questions allow me to isolate and track the influence that socio-political-econominc and historical context, institutional forces, and organizational structure have over time on mental illness treatment careers.

Subsequent empirical chapters describe the historical context (question 1) of the specific treatment phase, the cultural-cognitive elements (questions 2 and question 3), the normative elements (question 4 and question 5), and the regulative elements (question 6 and question 7) involved in change and stability within the mental health sector. However, questions two, three, and four do not deal with the cultural-cognitive and normative aspects of the organizational form and behavior; they deal with the cultural-cognitive and normative aspects of the social problem the institution is designed to address. Moreover, it is important to note that the regulative institutional element consists of both policy and legal decisions. Because the mental health literature has focused almost exclusively on policy decisions as explanations of treatment career change, this research does not include questions that get at this aspect of the regulative institutional element. However, this research refers to the review of policy decisions discussed in chapter two when necessary. Thus, Gove's (2004) modified engagement frameworks provide a basis for examining mental illness careers within various levels of social structural change and stability.

The Data

The data used to portray careers within specific treatment phases are drawn from previous literature and various descriptive datasets. The research uses primary sources such as the U.S. Census' *Patients in Mental Institutions* (1926, 1935-1946), U.S. Census' *2012 Statistical Abstract* (1955-2005), and the National Institute of Mental Health's *Patients in Mental Institutions* (1947-1966) which reports admissions to inpatient treatment in public and private mental hospitals. The National Institute of Mental Health provides various forms of descriptive data and reports from the 1960s to 2005 regarding changes in outpatient treatment, private practices, general medical practitioners, and psychiatric wards in general hospitals. Finally, the Government Accountability Office compiles data and writes reports for Congress on various topics. These reports are a valuable source of information describing the mental health system and careers during the phases of treatment.

My first research question, what was the socio-political-economic and historical context of the nation-state during the time a given mental illness career is experienced, is concerned with identifying any nationwide changes that potentially affect the mental health sector. I answer this question by looking to secondary sources that focus on the nation-state. While this is not an attempt to explore the context, it is an important attempt to identify specific times in this country's history that reverberate through its lower levels of social structure. My second question, who is considered mentally ill during different phases of treatment, is concerned with how mental illness is conceptualized. The primary source to answer this question includes the Diagnostic and Statistical Manuals. However, this question is also addressed through the use of various reports and articles that discuss

mental illness over time as well as how mental illness is conceptualized. Addressing this question is not an attempt to account for the number of mentally ill but an attempt to understand what types of mental illness are treated during the different phases.

My third question, identifying important patient characteristics exhibited in different settings, demonstrates how mental illness is treated during different phases and also indicates which disorders get treated in which locations. Thus, patient characteristics, such as acute disorders versus chronic disorders or psychotic disorders verses nonpsychotic disorders allow tracking of the conceptualization of mental disorders and its effects on the demographic composition of the mental health sector. Moreover, the conceptualization of mental disorders is dependent on the phase of treatment. Various governmental reports and publications provide primary data. For example, census data shows different diagnoses for the three treatment phases. Additionally, the census reports utilization by diagnoses for different organizations treating people with mental illness (i.e., both public and private hospitals, drug and alcohol centers, and nursing homes). The National Institute of Mental Health provides reports that describe the frequency of mental disorders within different organizations depending on the treatment phase. These sources show the characteristics that are important to treatment in differing organizational types during different phases.

My fourth question, how people with mental illness are treated during different phases, includes prevailing treatment logics or philosophies that are dominant in different phases. Policy documents and historical accounts are used to answer how mentally ill people are treated during different phases.

My fifth question, where people with mental disorders are treated during different phases, includes the predominant organizational forms and types used during a particular phase of treatment. Changes in treatment use from 1945 to 2005 can be traced through Census data as well as data from the National Institute of Mental Health. These sources show patients in hospitals for mental disorder in both public and private control and the treatment of mental disorder in different organizational forms.

To answer my sixth question, what are the legal, political, and administrative thresholds for initiating voluntary or involuntary treatment services during each phase, I examine various legal decisions and policy documents that mandate when and why treatment should and should not occur. These documents, along with historical accounts, are used to understand the legal decisions that guided both public and private policy and under what circumstances treatment should occur.

Finally, to answer my last question, I examine how patients are released from treatment during different phases. Various legal decisions and policy documents mandate when treatment should and should not end. These documents, along with historical accounts, are used to understand the legal decisions that guided both public and private policy as to when treatment should end.

The primary data used in this research answer question three: what are the patient characteristics that are important for treatment, and, question five: where are people with mental illness treated? These two questions can be answered using the following data sources: Patients in Mental Institutions for 1945-1947; Patients in Mental Institutions 1947-1966; Mental Health, United States 1985-2008; Utilization of Short-Stay Hospitals: Annual Summary 1965-1986; National Hospital Discharge Survey Annual Summary

1987-2005; United States Census 1963-1966; National Institute of Mental Health, Statistical Notes 1975-1993; and The National Nursing Home Survey 1977, 1985, 1997, 1999, and 2004. The remaining five questions are answered using secondary sources, including books and articles written by social scientists and historians.

Research plan

This research first describes the mental illness career in each of the three phases of mental health treatment using seven guiding research questions (Gove 2004). After describing careers in different treatment phases, I trace this process from a neoinstitutional perspective during each phase of treatment. This process describes isomorphic forces that affect treatment engagement and the mental illness career in each phase. In the final chapter I draw on various theoretical descriptions of mental illness and mental illness careers and the assumptions they have for patients' engagement in treatment to develop a theory from this analysis of the mental illness career. Using neoinstitutional theory and Gove's (2004) modified questions as an organizing framework I describe how various levels of social structural context influence the mental illness career. This theory models how socio-political-economic and historical context shapes the institutional environment and how these changes affect organizational forms used to treat individuals with mental illness. This provides an understanding of how larger organizational forces affect the engagement and career of people with symptoms of mental disorder.

Chapter 4: The Mental Illness Treatment Career during the Institutional Phase

This chapter covers the treatment careers of people with mental disorders during the institutional care phase from approximately 1945-1965. First, it provides a socio-political-economic and historical context to this particular phase of treatment. Next, because there is no clear understanding of the changing mental health sector and the consequences this has on mental illness careers, a description is provided of these processes. In order to document the treatment careers of people with mental disorders, this paper uses a modified version of Gove's (2004) framework for studying mental illness careers. Finally, this chapter uses neoinstitutional theory to describe the mental illness career.

Socio-Political-Economic and Historical Context of the Mental Illness Career

Prior to the 1940s, states provided the bulk of financial support to the mental health treatment sector. That is, the majority of resources paying for treatment, as well as policies created, occurred at the state level. Except for the care and treatment of veterans, the federal government was generally not involved with treating those who were mentally ill. However, as a result of the United States' experiences of the Great Depression and World War II, federal intervention had been legitimated across various institutional sectors, which had typically been the province of states' authority. The Great Depression and World War II created a socio-political-economic and historical context in which the federal government was needed to intervene and solve large economic and political problems (Grob 1991a). Moreover, society understood this intervention as largely successful (Star 1982), which changed how social, political, and economic relationships

were organized. This intervention changed these relationships by restructuring institutional environments.

State and county mental hospitals had been the main organizational forms for mental health treatment since the 1890s. After World War II, stories emerged from within state mental hospitals challenging their legitimacy (Dowdall 1999). These stories pointed to problems such as crowding, deterioration of physical structures, poorly trained staff, therapeutic failures, and dehumanization of patients. Both the public and the mental health profession began to lose faith in the traditional institutional logic of removing people from society and treating them within the confines of a large psychiatric hospital. Subsequently, both the treatment philosophy and patterns of hospitalization began to change during this phase (Grob and Goldman, 2006).

Even though the public lost faith in the traditional institutional logic, they did not lose faith in medicine and medical experts. According to Star (1982), science and scientific research were seen as playing integral roles in winning World War II. After the war, American medicine saw dramatic expansion. This growth in medicine was seen as contributing to American well being without requiring radical social change. Moreover, given America's new standing in the world as a wealthy country, health concerns shifted from a focus on infectious to chronic diseases such as cancer, heart disease, obesity and neurosis. This new impetus led to broader public approval of medical authorities regulating social behavior (Star 1982).

Psychiatry moved from the margins of the medical profession to the mainstream and expanded its claims about what made a "good" social life. Before the War, psychiatry was chiefly concerned with mental illness and psychiatrists were stationed within large

state and county mental hospitals. After World War II, psychiatry began to shift its focus toward mental health in the community and psychiatrists began to redefine social problems in medical terms arguing that therapy typically failed because it occurred too late in a person's life. Subsequently, broad based societal interventions were needed to improve societal mental health (Star 1982).

During the institutional treatment phase, treatments for people with mental illness began to experience changes. The institutional logic began to change from institutional forms of care to community-based forms of care. However, this change did not fully take place until the end of the institutional phase in 1965. Consequently, mental health treatment during the institutional phase slowly moved from being provided in large hospitals to being provided in new community organizations. The remainder of this chapter is devoted to describing this transition.

Categorizing Mental Illness

When examining who is considered mentally ill during the institutional phase it is important to understand this is an attempt to understand what mental illness is and how mental illnesses are classified during this particular treatment phase. However, this is not an attempt to count the number of people with mental illness. In the United States, during the 18th century, insanity referred to people who were violent and required supervision to prevent future acts of harm to themselves or others (Hurd et al., 1973). However, the idea of what mental illness is and how it is classified has changed over time.

In the United States, the first attempt to measure mental illness and mental retardation was in the U.S. census of 1840. The category "insane and idiotic" was used to denote people with mental illness or mental retardation (Grob 1991b; Manderscheid et al.

1986). The classification denoted two groups: "Idiotic" referred to people with congenital defects, and "insane" referred to people thought to be affected by brain lesions (Grob 1991b). People so labeled fell into two treatment categories: those under private care (at home) and those in public care (in hospitals or almshouses) (Manderscheid et al. 1986).

Ultimately, experts came to understand the Census did not accurately measure people with mental illness in the U.S. population. Moreover, a review of diagnostic classifications used by physicians found little agreement on the definition of insanity (Manderscheid et al. 1986). In an attempt to define the concept of insanity more accurately, the Superintendent of the Census, the New England Psychological Association, and others developed a classification scheme with seven forms of insanity for the 1880 census. These classifications were mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsia. In 1902, Congress prohibited the collection of data on special classes of people, which limited future census counts to patients in mental institutions (Manderscheid et al. 1986).

However, psychiatric interest in classification began to increase as the discipline shifted its focus to the course and outcomes of mental disorders (Grob 1991b). In the 1880s Emil Kraepelin focused on groups of symptoms as evidence of specific psychiatric problems, and ignored personal history (Grob 1991b). Following Kraepelin's nosology, the American Medico-Psychological Association and the National Committee for Mental Hygiene created the *Statistical Manuel for the Use of Institutions for the Insane* (1918). This manual provided a blueprint for mental hospitals for compiling their annual statistics of mental institutions. This manual came with twenty-two categories to classify residents of the mental institution (*Statistical Manuel for the Use of Institutions for the Insane*).

Twenty of the twenty-two diagnoses were based on the belief that mental illnesses were biologically caused (Grob 1991b) and symptoms of mental illness were almost always expressed as some form of psychosis (Horwitz 2002b). Because of this standardization, patient diagnoses were incorporated into the Census' *Patients in Mental Institutions* for 1923, 1933, 1939-1946. This classification system was eventually adopted and used by the Surgeon General of the Army (Manderscheid et al. 1986).

However, this classification system and later revisions were not totally accepted. One of the major opponents of the Kraepelinian nosology was Adolf Meyer, who advocated including individual life experiences with physiological and biological data. Nevertheless, this classification system remained dominant until the early 1940s (Grob 1991b). With the increased need for manpower during World War II, subtle mental disturbances became more important in the military than in civilian and hospital settings (Houts 2000; Rains 1966). According to Grob (1991b), "World War II marked a watershed in the history of mental health policy and the evolution of American psychiatry. Many psychiatrists who served in the military came to some novel conclusions. They found that neuropsychiatric disorders were a more serious problem than had previously been recognized, that environmental stress associated with combat contributed to mental maladjustment, and that early and purposeful treatment in non-institutional settings produced favorable outcomes" (pg. 5). Subsequently, the Kraepelinian model lost legitimacy in the discipline of psychiatry (Rains 1966).

By the end of World War II there were three different taxonomies used to describe mental illness: the Standard Classified Nomenclature of Disease, the Armed Forces Nomenclature (Medical 203), and the Veterans Administration Nomenclature

(Houts 2000). None of these three taxonomies, however, met the criteria of the World Health Organizations International Statistical Classification. Moreover, most teaching centers modified the Standard Classified Nomenclature of Disease. Additionally, psychiatrists returning from military service altered Medical 203 for their own purposes, leading to even more confusion about the classification of mental disorders (Rains 1966).

From this confusion, the Committee on Nomenclature and Statistics of the American Psychiatric Association tried to determine psychiatric willingness to adopt a new standard for diagnosing mental disorders. A majority of members believed a new standard was needed. However, the need for change was most prevalent among psychiatrists in clinics and private practice than those practicing in mental institutions. There was a particular interest in personality disorders and temporary reactions to stressful situations. From this effort the *Diagnostic and Statistical Manual of Mental Disorders* (DSM I) was published in 1952 in order to provide standard criteria for the classification of mental disorders (Rains 1966). DSM I came out of a psychosocial framework that argued the boundary between mental health and illness was in constant flux refuting Kraepelinian nosology. Kraepelinian nosology ignores the individual's personal history and sees a group of symptoms as a discrete disorder. According to the psychosocial framework the state of flux is a consequence of individual inability to adapt to their environment. The psychosocial framework views mental illness along a continuum ranging from neurotic to psychotic in reaction (Wilson 1993).

Although these psychiatric nosologies do not ascribe a specific diagnosis to an individual in treatment, they demonstrate that the mental disorders considered important during the institutional phase were different from what subsequent generations

considered important. The emphasis during the institutional phase was on psychotic or chronic forms of mental illness. For example, in the *Statistical Manual for the Use of Institutions for the Insane* (1918), the overwhelming majority of the twenty-two diagnoses deal with some type of psychoses and/or brain disorder, two did not: psychoneuroses, and not insane categories. Moreover, these diagnoses were based on the Kraepelinian nosology (Grob 1991b). Whereas the DSM I divided mental disorder into two broad groups the first categorized cases of mental dysfunction as a consequence of brain impairment (i.e., brain disorder). The second categorized cases as resulting from an inability to adjust and viewed the mental dysfunction as secondary. This second categorization had two subgroups: psychotic and the psychoneurotic disorders. Psychotic disorders were disorders such as manic depressive, paranoid reactions, and schizophrenia. Psychoneurotic disorders consisted of anxiety, dissociative, phobic, obsessive-compulsive, and depressive disorders. There were also personality disorders and reactions related to age differences (Grob 1991b: 428). The broadening of the classification schema for the nonpsychotic diagnosis supported the psychosocial framework and allowed professionals to advocate treatment in non-institutional settings.

From this perspective, the importance of World War II cannot be overstated because it led to an intellectual shift in the discipline of psychiatry. This shift changed the conception of mental illness and the way patients received treatment. Prior to the war, psychiatry was largely practiced within institutions and the patient population largely consisted of people with psychotic and chronic mental illness. During the war there was a tremendous need for psychiatrists who understood and could treat emotional disorders

resulting from a stressful environment. This encouraged the belief that environmental stress contributed to mental illness (Grob 1991b).

When examining this history, we can observe that in the beginning of the institutional phase—the mental hospital was the central treatment facility of the mental health system—the understanding of mental illness, as represented by psychiatric nosology, were more psychotic and chronic types of illness and fit the Kraepelinian nosology. This understanding did not begin to change until the country mobilized for World War II and the psychosocial model was implemented. This new conception of mental illness was reified in 1952 with the DSM I, which had profound implications for the treatment career of people with mental disorders.

Patient Characteristics

A second question is which patient characteristics are important during a particular phase. For example, do the patients have types of mental illness that require treatment over a long period or problems that may require intense intervention, but relatively short treatment? Albert Deutsch (1973) suggests two ways of classifying types of psychiatric disorders, which fit a chronic/acute dichotomy: "The milder mental-emotional [and]…psychosis" (p 25). The milder emotional problems are typically classified as neuroses and psychoneuroses. Psychosis, however, is a more chronic diagnosis, which includes schizophrenia (dementia praecox), manic-depression, paranoia, involutional melancholia, general paralysis, and senile psychoses etc. (Deutsch 1973). Emotional problems are generally treated in an outpatient setting, whereas psychosis typically results in hospitalization (Deutsch 1973). This understanding of mental illness

follows Gove's (2004) logic in classifying symptoms into the less serious lay category "nervous breakdown" and the more serious lay category "mental illness" (358).

However, this chronic/acute dichotomy may not correspond with where patients receive treatment. Stanton and Schwartz (1954) argue the psychiatric hospital must produce an administrative diagnosis along with a psychiatric diagnosis. The administrative diagnosis pinpoints what the patient needs from the hospital. This diagnosis is fashioned from certain assumptions about the patients entering the hospital. Administrators assume patients enter because of certain failures in their lives. These failures symbolize what patients need from the hospital and are not apparent, and must be discovered. The needs of the patients are extensive and heterogeneous. For example, patients may need protection from suicide, spending excessive amounts of money, separation from temptations, and/or encouragement. However, a small number of patients need all the administrative services (Stanton and Schwartz 1954). The administrative diagnosis is constructed from a patient sketch through family and patient interviews. Although this procedure was not formalized, it was observable in staff conferences, conversations among nurses, occupational therapists and aids. Moreover, psychiatrists and administrators knew the procedure. These diagnoses were an important indicator of the patient's condition and of their subsequent progress (Stanton and Schwartz 1954). Moreover, this classification system connects the therapeutic and the custodial functions of the hospital (Belknap 1956).

In *Human Problems of a State Mental Hospital*, Ivan Belknap (1956) describes the patient population of a state mental hospital in this chronic/acute dichotomy. Belknap (1956) asserts about 49 percent of cases are furloughed or discharged from the hospital

after a year. Patients in this group typically leave the hospital within a year and can receive the classification as improved, unimproved, or cured. If they are furloughed, they may remain on the books as patients; however, the hospital typically ends its responsibility as patients leave the grounds. If patients remain in the hospital, they form a permanent population. Most of this static population had one of four diagnoses: "schizophrenia; psychosis with cerebral arteriosclerosis; senile psychoses; and a group of psychotic disorders 'associated with' mental deficiency" (Belknap 1956: 59). Finally, some of these static patients are thought of as hopeless cases, while other are considered institutionally cured—those who function well inside the hospital structure but not outside (Belknap 1956).

In fact, Belknap (1956) argues there are three classification systems used: the first is the standard medical diagnosis. The second is what Stanton and Schwartz (1954) referred to as the administrative diagnosis and what Belknap (1956) calls the institutional classification, which is used to connect the hospitals role in treatment to their custodial functions. The final classification, the ward classification, is unofficial and unacknowledged but linked to the administrative diagnosis. "The ward classification distributes the patients in terms of their manageability and occupational utility on the ward and in the hospital work. Just as the APA [American Psychiatric Association] categories may describe little of the patient's position in the hospital's institutional classification, the latter may give little information about the patient's status on the ward" (Belknap 1956: 128-29). Patients were placed in wards without regard to the administrative and/or the medical diagnosis. For example, from an administrative diagnosis, patients with entirely different administrative needs were placed in the same

ward together. From the perspective of medical diagnosis, patients with entirely different medical problems were in wards together, such as patient with neurosis in wards with patients diagnosed with schizophrenia, advanced cases of paresis, and mentally defective psychotics. The ward classification ignores any official classification and provides a ready labor force used to maintain the wards and hospitals by distributing patients with the ability to work in different wards (Belknap 1956).

Belknap (1956) and Stanton and Schwartz (1954) elucidate the importance of classificatory schemas and how they are used for dealing with patients. In addition to these sources, and similar to Deutsch's (1973) and Gove's (2004) work, Grob (1991a) suggests the DSM-I classifies mental disorders into three major groupings: Brain impairment, which consists of cases of disturbed mental function was a consequence of damage to brain functioning. Two subgroups of disorders: psychotic and psychoneurotic disorders, which represent problems with a person's ability to adjust to their environment. These sources would suggest there are three distinct and broad classifications for people with mental disorders: brain impairment, psychotic disorders, and nonpsychotic disorders (Appendix A and Appendix B).

Using these three broad classifications as aggregates to examine the Census reports *Patients in Mental Institutions* for 1945-1947 and the National Institute of Mental Health reports *Patients in Mental Institutions* 1947-1965, important trends present themselves (Figure 2). First, upon a patient's initial admission, assignment to the category nonpsychotic increased over the twenty-year period, with a growth rate of 192 percent over twenty years (1945-1965). Nonpsychotic consists of disorders such as psychoneurosis, psychophysiologic autonomic and visceral disorders, transient situational

personality disturbance, mental disorder undiagnosed, and personality disorders (Table

1). Moreover, as the percentage of first admission for nonpsychotic disorders increased

the percentage of first admissions for patients who were diagnosed with brain impairment

and psychosis decreased. Brain impairment disorders decreased by 44 percent and

patients diagnosed with psychoses decreased by 38 percent over twenty years (Table 1).

Some of the decrease in patients diagnosed with brain impairment disorders was due to

new developments, such as penicillin for treating central nervous system syphilis

(Callaway 2007).

Table 1. First Admission Diagnosis Growth Rates from 1945-1965

Diagnosis	1945-1955	1955-1965	1945-1965
Brain Impairment	-17%	-32%	-44%
Psychoses	-17%	-25%	-38%
Nonpsychotic	80%	62%	192%

Source *Patients in Mental Institutions* 1945-1946 U.S. Census and *Patients in Mental Institutions* 1947-1966 from the National Institute of Mental Health

Trends in Figure 2 provide support for Grob's (1991) argument that the change

from Kraepelinian to psychodynamic or psychosocial nosology began after World War II.

Moreover, it took place over time. The category nonpsychotic, generally corresponds

with Grob's (1991a) understanding of psychoneurotic disorders (428). Another important

point about Figure 2 is it represents percentage of first admissions and not the raw

numbers. The raw numbers show that as the patients' with nonpsychotic disorders

increase, admission for brain impairment and psychoses stayed relatively constant. What

the percentage of first admission by type of disorder indicates is the increasing first

admissions from more chronic disorders (i.e., psychosis and brain impairment) to more

acute or emotional problems (i.e., nonpsychotic disorders) did not happen all at once.

Moreover, it was psychiatrists' gradual readjustments of their cultural-cognitive

conception and the subsequent change in organizational behavior that increasingly

emphasized a particular category of disorders. This readjustment occurred because

nonpsychotic disorders corresponded with the popular—psychosocial/psychoanalytic—

conceptualization of mental illness, which saw mental illness occurring along a

continuum of severity that ranged from the neurotic to the psychotic. Moreover, this

framework suggested the earlier the intervention in a mental health problem the more

successful the treatment outcome.

Figure 2. Percent of First Admission to State and County Mental Hospitals by Disorder 1926 to 1972[5]
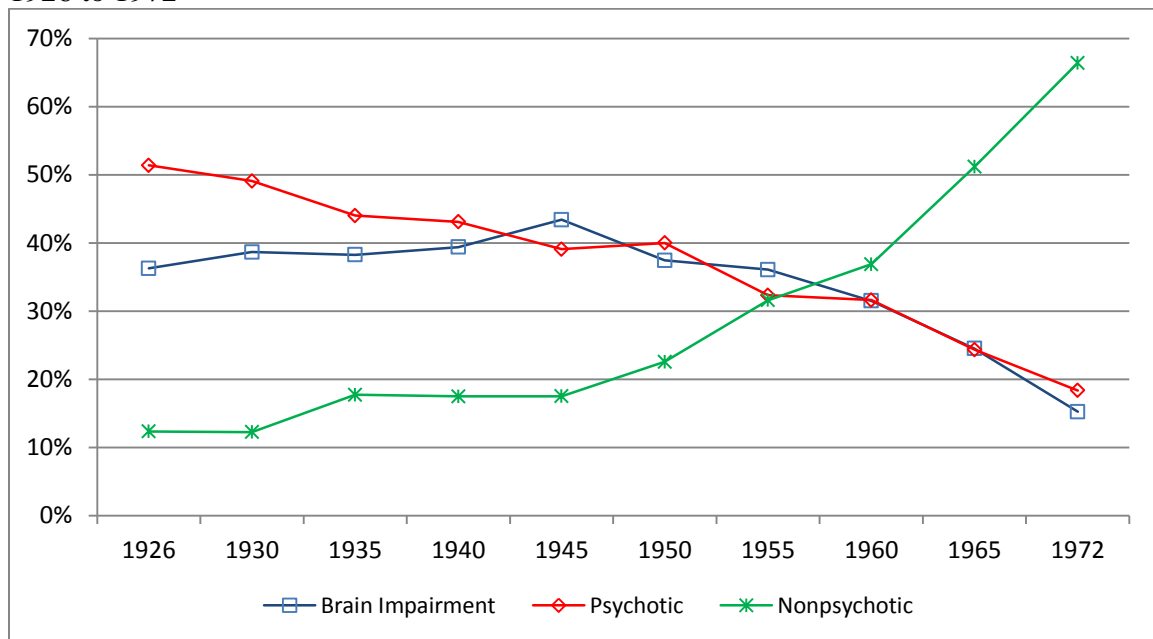
Source. *Patients in Mental Institutions* U.S. Bureau of the Census 1926 1935-1946 and *Patients in Mental Institutions* 1947-1965 from the National Institute of Mental Health and the National Institute of Mental Health and Kramer (1977) National Institute of Mental Health Series B, No. 12

In fact, Figure 3 shows the percentage of resident patients in state and county

mental hospitals at the end of the year from 1950 to 1965. More residents brain

impairment and psychotic groups of disorders than nonpsychotic groups of disorders.

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[5] The years 1926 and 1930 only contain information about state hospitals, whereas the years 1935 to 1972 contain information about state and county mental hospitals (public prolonged-care hospitals).

Even though those with the nonpsychotic groups of disorders were increasingly being admitted to the hospitals, people with brain impairment and psychotic disorders were chronic cases that required more time in the state and county mental hospitals. Moreover, Figure 3 shows how the implementation of the DSM-I affected the composition of resident patients. First, it shows that after 1952 there was a sharp decrease in percentage of resident patients with psychotic disorders and an increase in the percentage of patients with brain impairment disorders. There was relatively little change in the percent of patients with nonpsychotic disorders during this time. Taken together, the percentage of resident patients by type of disorder demonstrates that the implementation of the DSM-I affected the composition of resident patients, but not enough to radically transform patient characteristics in state and county mental hospitals. Equally important, Figure 3 reveals that the implementation of the DSM-I and not the introduction of psychotropic medication altered the composition of state and county hospitals. Widespread distribution of psychotropic medication did not occur until 1954 (Braslow 1997; Lael, Brazos, and McMillen 2007).

Figure 3. Percent of Resident Patients in State and County Mental Hospitals at the End of Year by Type of Disorder
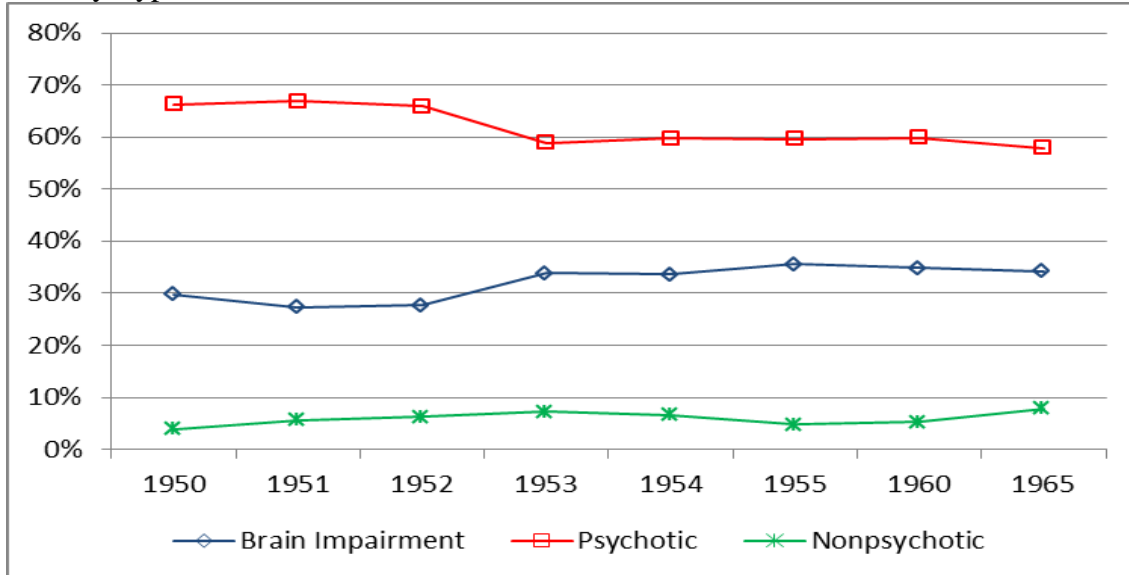
      Coupled with the trends in diagnosis is the age pattern of first admission to state and county hospitals from 1945 to 1965 (Figure 4). The age categories 15-24 and 65 years and older went through dramatic changes during this treatment phase. First, people aged 15-24 years dramatically increased their percentage of first admissions from 1955 to 1965. Juxtaposing this trend is the decreasing percentage of first admissions to state and county hospitals for people aged 65 and older, from 1955 to 1965 (Figure 4). There is no doubt that this trend was accelerated in 1965 by the implementation of Medicaid and Medicare and the increased importance of nursing homes. However, the percent of first admissions for young people and percent of first admissions for old people are not explained by the transfer of old people to nursing homes. This phenomenon also appears to reflect the changing conceptualization of mental illness. For example, patients with less chronic and more acute types of mental illness tend to be suffered by younger individuals whereas patients with more chronic brain impairments tend to be suffered by old people.

Figure 4. Percent of First Admissions to State and County Mental Hospitals by Age for
1945 to 1965
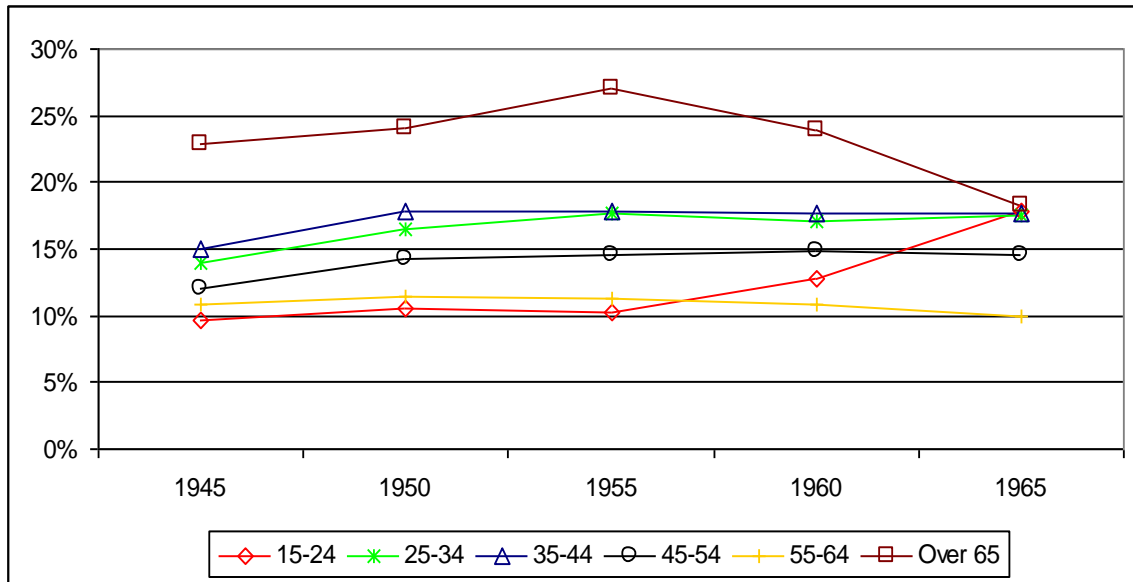
Data Source *Patients in Mental Institutions* 1945-1965 from the National Institute of
Mental Health and Kramer (1977) National Institute of Mental Health Series B, No. 12

When examining percentage first admissions for 15-24 year olds and those older
than 65 by type of diagnosis the data show, from 1945 to 1965, nonpsychotic disorders
becomes increasingly more prevalent for 15-24 year olds and brain impairment disorders
become decreasingly prevalent among those older than 65 years or older (Figure 5).
Suggesting the change in the way mental illness was conceptualized broadened the
professionals' focus, from focusing exclusively on chronic conditions to include acute
types of illness and changed the demographic composition of the state and county mental
hospital to include more and more young people.

Figure 5. Percent of First Admissions to State and County Mental Hospitals by Age for 1945 to 1965
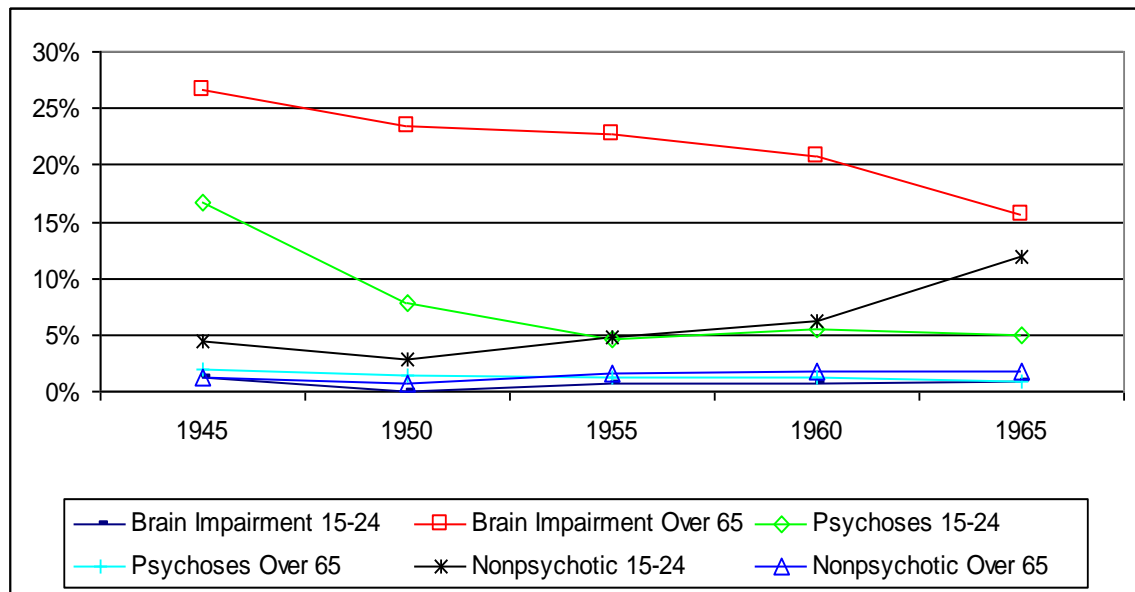
Source *Patients in Mental Institutions* 1947-1966 from the National Institute of Mental Health

Data from the National Institute of Mental Health help us understand what patient characteristics were important for the treatment of mental illness. Moreover, they suggest those with serious mental illnesses, although a large part of the population, were not the only patients that made up the population of state and county hospitals. It appears mental institutions were used to treat mental illnesses that required treatment over both long and short durations. Both previous works and the data suggest patient characteristics, along the chronic/acute dichotomy, were more as Deutsch (1973) suggests psychotic or chronic forms of mental illness towards the end of World War II and begin to transition to include more nonpsychotic or acute forms of mental illness as time progresses. Paralleling this trend is the dramatic increase in percent of first admissions for 15-24 year old patients.

What is significant about all these trends is they demonstrate the consequence of a profession's cultural-cognitive readjustments, which broadened the focus of mental disorder from psychotic—dominant in the institutional phase—to the increase importance

of nonpsychotic or acute forms, such as personality and neurotic disorders. These trends suggest how the change in the understanding of mental illness or its nosology has important implications for the demographic composition of the dominant organizational form, the state and county mental hospital. This trend corresponds with the intellectual shift, described by Grob (1991a) and Wilson (1993), in the discipline of psychiatry from Kraepelinian model and descriptive diagnosis to a unified psychosocial theory of psychopathology and the subsequent change in organizational behavior.

Treatment Patterns and Theories

Considering what types of treatment are used and how they are justified is another important aspect to consider when examining the treatment career. This is important because the professional conception of mental illness should dictate which treatments are used. This section will first examine the various forms of treatment employed and their justification. Then it looks at what implication this has for the patients' treatment career, during the institutional phase. Horwitz (2002b) defines therapeutic treatment for mental patients as the attempt at transforming a person's disturbed thinking, outlooks, and actions. There are two broad categories of treatment methods: physical and psychological therapies[6]. Physical therapies feature exogenous acts or substances that directly affect individuals' bodies or brains, whereas psychological therapies engender change through use of "cultural symbols and so rely on the power of language and human understanding to heal mental suffering" (Horwitz 2002b: 181).

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[6] Occupational therapy would seem to broach both physical and psychological categories. For example, both Lael, Brazos, and McMillen (2007) and Callaway (2007) suggest the particular state hospitals they describe had various activities or jobs that patients could engage in, if able, during their time in the hospital. In fact Callaway (2007) describes symptoms of a patient with schizophrenia being ameliorated by working with dairy cows.

However, Braslow (1997) documents and argues the history of psychiatric treatment shows a spiraling "closer and closer to the interior of the brain. From merely applying water to the skin with hydrotherapy to the severing of frontal lobe axons with lobotomy to, finally, giving medications that putatively act at precise neurotransmitter sites, the brain increasingly took center stage as a source of disease and a site of cure" (Braslow 1997: 3). Physical therapies during this phase were composed of various treatments such as hydrotherapy, fever therapy, shock therapy, lobotomy, and psychotropic drugs (Braslow 1997; Lael et al. 2007). Hydrotherapy consisted of two methods of using a continuous bath and wet sheet packs to work on patients through complex physiological and biological mechanisms. For example, some thought it relived cerebral congestion by affecting the peripheral vascular system, while others thought it eliminated toxic impurities that caused insanity (Braslow 1997). Fever therapy used heat to relieve symptoms of mental disorder. This heat could be derived from an injection of a fever producing agent, such as malaria or typhoid or could be generated by lights (Lael et al. 2007).

There were three types of shock therapies used: insulin, metrazol, and electric shock. Insulin shock actually produced a physiological shock but no seizures, while the other two created grand mal seizures. The theoretical justification was that there was a polarity between epilepsy and schizophrenia and inducing seizures would help relieve symptoms. However, this idea was disproven and there was no real compelling theoretical justification for its efficacy (Braslow 1997). Then electric shock therapy was joined by transorbital lobotomies as a treatment method. Lobotomies had a scientific

rational for dramatically altering behavior; however, there was little agreement on the exact reason it worked to modify behavior.

After the introduction of psychotropic medication in 1954, doctors abandoned these therapeutic methods for chemical therapies (Braslow 1997). During the 1950s, the development of psychotropic drugs, whether directly or indirectly, changed patients' careers. The introduction of psychotropic drugs—a normative force—helped to increase release rates and decrease length of stay in mental hospitals. In theory, psychotropic drugs would enable chronically mentally ill people to participate in psychodynamic and psychoanalytic therapy by diminishing psychosis and making them more receptive to self-reflection. These psychotropic drugs were widely distributed and helped diminish severely mentally ill patients' psychotic symptoms (Mechanic 1969). With the introduction of psychotropic drugs, a sense of confidence was given to mental health professionals and the public, as well as bureaucrats, and family members. It was thought that these drugs would help patients escape the state hospitals by allowing them to move back into the community (Mechanic 2008). Regardless, the evidence suggests that retention and release rates were affected more by administrative changes in hospitals than the drugs themselves (Gronfein 1985; Mechanic 1969). "Moreover, the new attitudes that developed during the period in which the psychoactive drugs were introduced led to vast changes of programs, procedures, and attitudes toward patients" (Mechanic 1969: 62). Despite these changes, state hospitals still had the problems of overcrowding and inadequate staff to patient ratios, inhibited patient contact with staff, which hindered treatment (Mechanic 1969).

Psychological therapies were guided by the psychodynamic or psychoanalytic orientation towards mental illness. Subsequently the practice of psychoanalysis was the dominant form of therapy during this phase. After World War II, there was more receptivity towards psychodynamic and psychoanalytic therapy. These models stressed life experiences and environmental factors (Grob 1991b). Deriving its justification from the psychosocial model, the goal of psychotherapy was to "understand the meaning of the symptom and undo its psychogenic cause, instead of manipulate symptoms" (Wilson 1993: 400). Psychotherapy became an important and much-admired treatment, which was employed by various professionals from psychiatrists to social workers (Grob 1991b). Despite its popularity, this treatment method did not have widespread and reliable results and could not deal with the problems that people in the large state and county mental hospitals had (Kirk and Kutchins 1992).

Even before 1945, when the conception of mental illness and places where treatment occurred remained relatively stable, the types and popularity of treatments underwent numerous changes. However, if treatments are based on the professional conception of mental illness, what do the various forms of treatment during this phase suggest? Braslow (1997) asserts what changed is how physicians understood a treatment's value. He suggests, "whatever biological consequences a particular therapy has [they] are mediated by and interpreted through the way doctors see disease and its cure, which are themselves determined by therapeutic practice" (5). However, physical restraints were what every treatment was compared to, despite restraints not being thought of as therapeutic. It follows that the various forms of treatment during this phase indicate that physicians' conceptualizations of mental disorders were centered on

psychotic or chronic forms of mental illness. Consequently, their treatments emphasized "control" over patients in a physical location, which did not begin to change until the conception of mental illness changed. When the conceptualization of mental illness changed, the emphasis changed from controlling methods (i.e., hydrotherapy, shock therapy, and lobotomy) in a physical space (i.e., mental hospital) to less controlling methods of treatments (i.e., psychoanalysis) in a less restrictive physical space (i.e., outpatient facilities). However, this change took the 20 years of the institutional phase to implement.

Nevertheless, there would appear to be one caveat to this interpretation, with the introduction of psychotropic drugs as a form of physical therapy. This treatment enabled people with psychotic or chronic forms of mental illness to participate in treatment. Psychotropic drugs facilitated control over and helped the staff work with patients (Mechanic 1969). State and county hospitals began to treat the patients instead of warehousing them (Dowdall 1996). Better physical facilities, more personnel, and the use of psychoactive drugs led to the changes, which facilitated ever-increasing number of patient receiving: releases, grounds privileges, and living on open wards instead of the traditional locked ward. Therefore, it would seem that the introduction of psychotropic drugs—a normative force—shifted the need for control over the person because it allowed the patients some control over their symptoms not the cultural-cognitive change in the conceptualization of mental disorders. However, the standard organizational form used to treat mental disorders was still the large state and county mental hospital. Although it may be true that the introduction of new physical and psychological therapies helped, what is important to keep in mind is that it was the combination of both the

cultural-cognitive—change in how mental disorders were conceptualized—and the normative—change in the physical and psychological forms of treatment—isomorphic forces that led to a re-conceptualization of the appropriate organizational form used to treat patients with mental disorders.

Where Treatment Occurs

In answering the question of where treatment occurred during the institutional phase, it is first important to note that during this phase, treatment was mainly practiced within state and county mental hospitals (Grob 1991a). Despite some exceptions, hospitals provided the majority of treatment, known as inpatient services. There were four principal types of mental hospitals: large state and county mental hospitals, Veterans' mental hospitals, small private psychiatric hospitals, and psychiatric wards of general hospitals, which provided inpatient services (*Joint Commission on Mental Illness and Health* 1961). In fact, in 1948, about 50 percent of all patients in hospitals during a single day were mental patients'; the majority of these were in state hospitals (Deutsch 1973). For example, Deutsch (1973) suggests most Americans hospitalized for psychosis in 1948 were sent to state institutions, where "nearly 85 percent of the institutionalized mental patients in the United States are maintained" (33). A decade or so later Belknap (1956) and The Joint Commission on Mental Illness and Health (1961) argue state institutions represent, for about eighty percent of patients, the only agency treating serious mental illness. Foley et al., In *Mental Health, United States* (2004), suggests the percentage of patients treated in state and county mental hospitals were 77 percent in 1955 and about 60 percent in 1965.

Examining where treatment occurs during this phase also requires us to understand who received treatment and where they received it. The first half of the 20th century shows disproportionate differences regarding those who received mental health treatment and if received, where treatment was received. Unless significantly disturbed or disruptive, lower status individuals did not receive treatments for mental illness. If patients were disturbed they were placed in state or county mental institutions and received custodial care with little to no active treatments (Mechanic 2008). The medical profession understood treatment was prohibitive and the majority of citizens would need state support for care (Deutsch 1973). In 1890 New York adopted complete state care: "all indigent insane would be maintained in state hospitals at state expense" (Deutsch 1973: 36). Other states followed suit, so much so that half of the 48 states had similar programs in 1948, although some states had no clear policies. Nevertheless, all states had at least one state or county hospital (Deutsch 1973) Thus, state or county hospitals became the standard organizational form treating people with mental disorders and the variance in organizational form decreased.

Dowdall (1996) describes an important transition in state and county mental hospitals from custodial care to active treatment of mental patients, towards the end of this phase. He suggests better physical facilities, more personnel, and the use of psychoactive drugs led to the change in inpatient care. This was evidenced by the ever-increasing number of patient releases, their receiving grounds privileges, and living on open wards instead of the traditional locked ward. Figure 6 and Figure 7 support Dowdall's (1996) argument. First, Figure 6 shows how the number of full-time employees in state and county mental hospitals increased substantially over the course of

twenty years compared to the average daily patient population. Specifically, the number of nurses and attendants increased more than other job categories. Figure 7 shows an increase in spending over the twenty-year period. What these two graphs indicate is that state and county mental hospitals began treating instead of warehousing patients, this required more personnel to manage patients and increased overall costs.

Figure 6. Total Full-Time Employees and Average Daily Resident in State and County Mental Hospitals
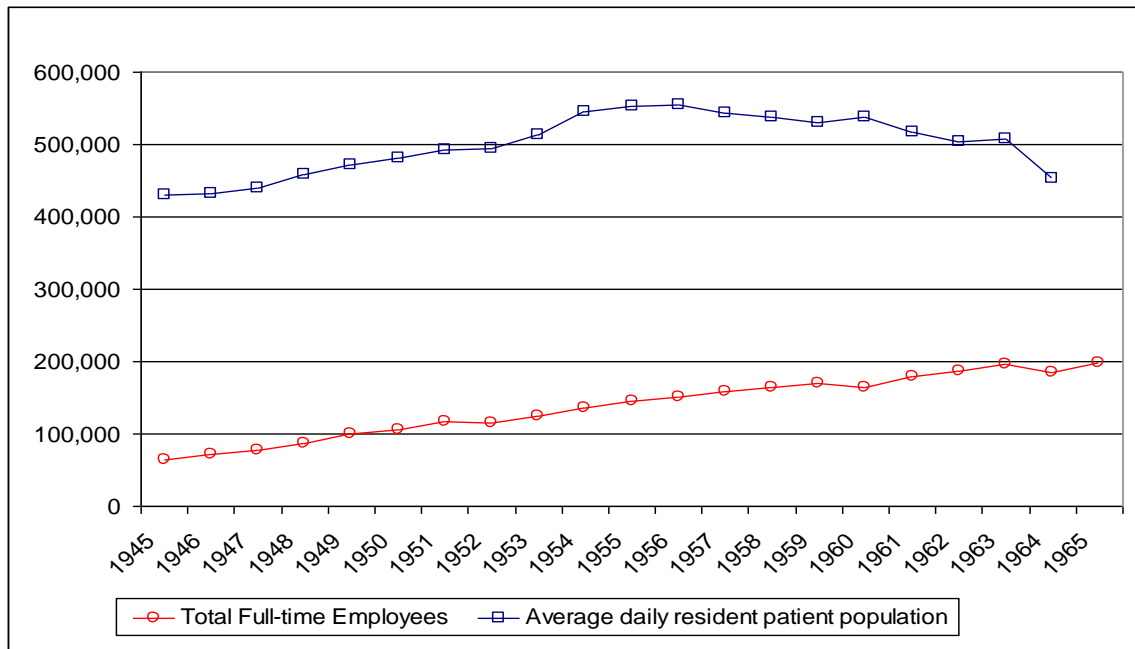
Source *Patients in Mental Institutions* 1947-1965 from the National Institute of Mental Health

Figure 7. Total Expenditure in State and County Mental Hospitals by Average Daily
Residents in 2005 dollars
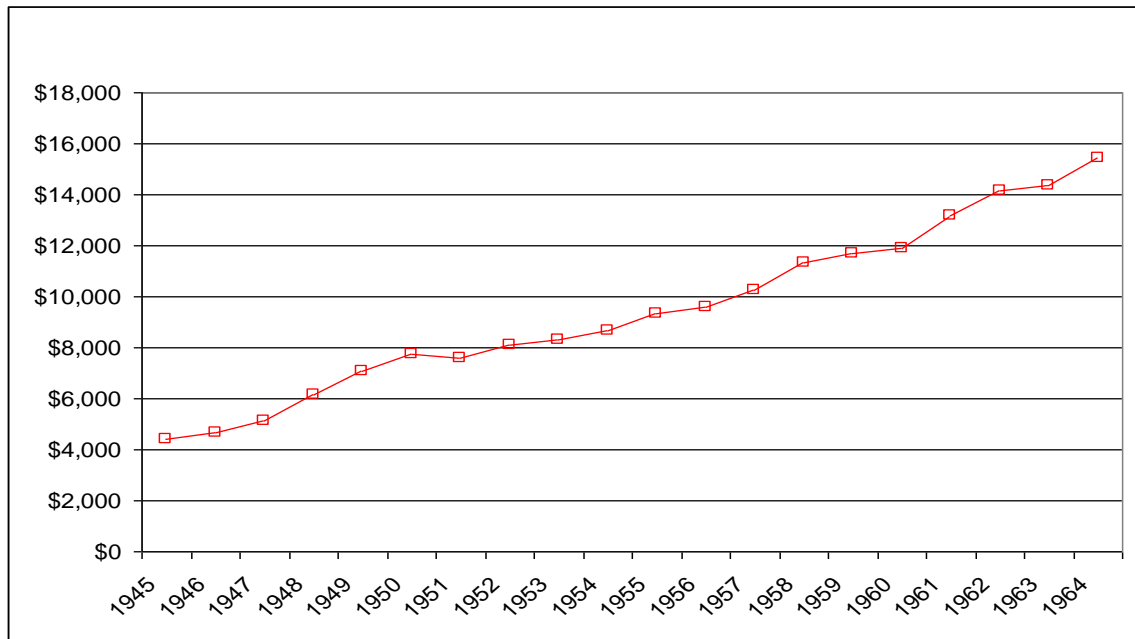
Source *Patients in Mental Institutions* 1947-1965 from the National Institute of Mental
Health

There were, nevertheless, some exceptions to where treatment occurred during

this phase. For example, if patients and/or their family were financially well off they

could go to small sanitariums, which were private hospitals (Deutsch 1973). However,

this was expensive and if the patient had a chronic disorder, they too could end up in a

state or county hospital (Mechanic 2008). If the case does not require hospitalization, a

psychiatrist in a private practice or an outpatient clinic can treat the patient, on a fee-for-

service basis (Deutsch 1973; Mechanic 2008). In 1948, about 1,500 psychiatrists

provided private therapy. If the patient lived in a large city, they could go to a general

hospital with a psychiatric ward or a psychopathic hospital for observation. If the person

in question is a veteran, they could seek treatment in either a Veterans Administration

hospital or a clinic (Deutsch 1973). The overall trend in the use of small private and/or

Veterans Administration hospitals is shown in Figure 8, which displays how both

Veterans and private psychiatric hospitals account for a smaller percentage of patient care episodes during this phase.

In Veterans Administration hospitals, the picture was different than state and county hospitals. These hospitals had more funds, higher staff to patient ratios, more research on different therapeutic methods, and a receptive attitude towards new trends in treatment. Psychiatric wards of general hospitals were typically used for short-term care. The trend was for larger hospitals to add psychiatric wards, which were typically oriented toward treating acute, rather than chronic disorders leading to higher patient turnover (Joint Commission on Mental Illness and Health 1961). The small private hospitals tend to be the leaders in terms of psychiatric treatment and quality personnel; however, they do not treat enough patients with mental disorders to affect the overall population. Most patients in private hospitals are from higher socioeconomic strata, typically diagnosed with nonpsychotic or neurotic rather than psychotic disorders, and if diagnosed with a psychotic disorder tended to suffer from depression compare to schizophrenia (Joint Commission on Mental Illness and Health 1961). Although professionals in private practices and hospitals led the field in developing treatment, most patients were cared for in public institutions (Joint Commission on Mental Illness and Health 1961), which suffered from overcrowding, understaffing and limited access to therapeutic equipment (Deutsch 1973).

Whatever the hospital type and location, the standard treatment provided was inpatient services. Redick et al. (1990), shows the frequency of patients' care episodes by type of inpatient organization from 1955 to 1965 (Figure 8). As we can see from Figure 8, inpatient care episodes predominantly occurred in state and county mental hospitals.

Redick et al. (1990) research shows that psychiatric wards of general hospitals became more and more important during the later part of institutional phase. Figure 8 depicts the incorporation and use of the psychiatric wards in general hospitals for treating patient care episode, which coincides with the increase number of psychiatric wards of general hospitals shown in Figure 11, during this time.

Figure 8. Number of Inpatient Care Episodes, by Type of Organization for 1955 and 1965
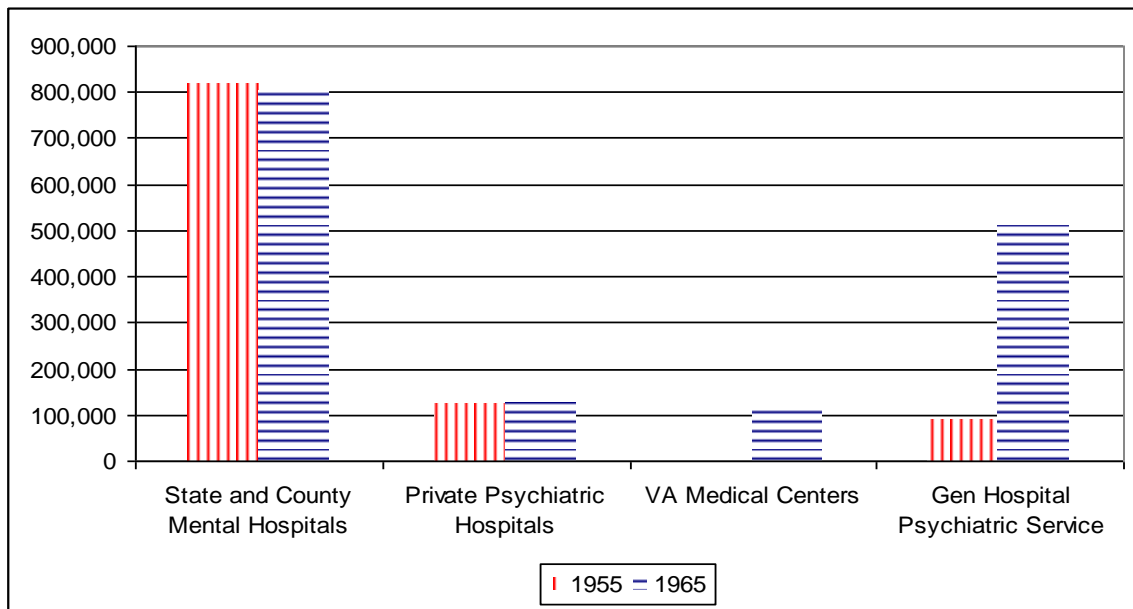
Source Mental health Statistical Note no. 192 *Patient Care Episodes in mental health Organizations, United States: Selected Years between 1955 and 1986*

Towards the end of the institutional phase variance between organizational forms increased and the structure of treatment began to change from inpatient treatment to outpatient treatment, which was the consequence of policies leading to deinstitutionalization. Outpatient services were provided by a number of facilities including both private and public organizations. They provided emergency services, extend treatment into community settings, and broaden the conceptions of care, including pharmacologic and psychotherapy, with varying degrees of intensity (Joint Commission on Mental Illness and Health 1961).

Redick et al. (1990), looking at the patient care episodes by type of treatment service during 1955 shows 77 percent occurred in an inpatient settings, 23 percent occurred in partial care settings, and none in outpatient settings (Figure 9). A patient care episode is defined as the number of patients in a treatment organization at the beginning of the year plus any additions to these organizations during the year. Although patient care episodes allow patients to have more than one treatment in a given year, it gives us an idea of where treatment is occurring. Figure 9 shows in a ten year period the rapid increase in the number of patient care episodes in outpatient settings.

Figure 9. Number of Patient Care Episodes by Type of Service 1955-1965
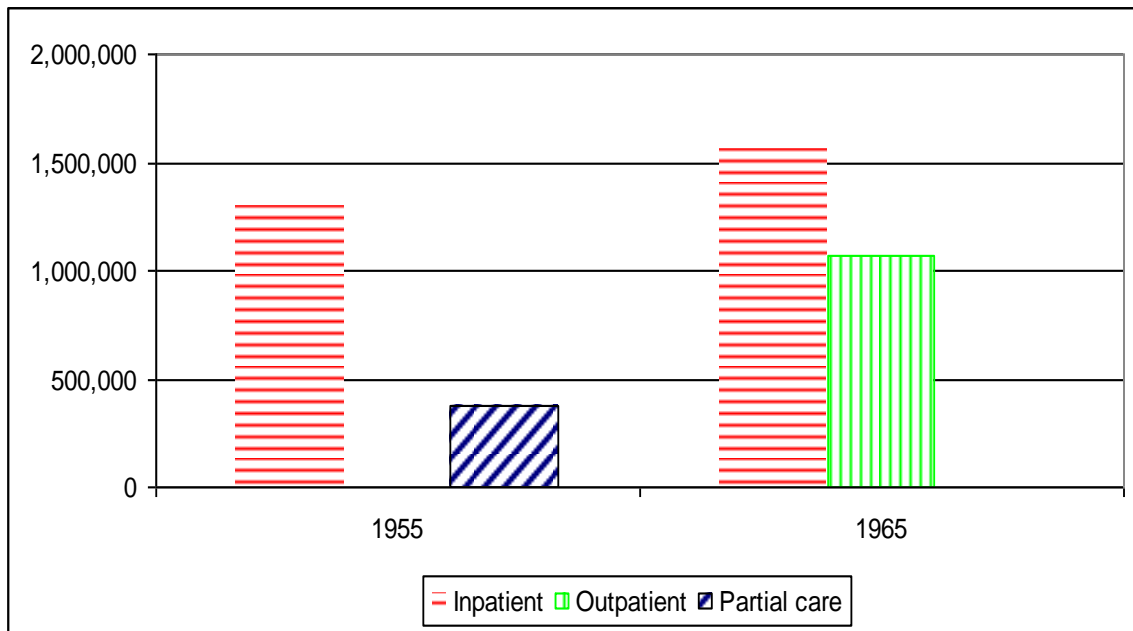
Source Mental health Statistical Note no. 192 *Patient Care Episodes in mental health Organizations, United States: Selected Years between 1955 and 1986*

Along with this, Figure 10 shows an increase in the overall patient population in outpatient psychiatric clinics from the late 1950s to 1965. Examining the U.S. Census 1963-1966 and *Patients in Mental Institutions* 1945-1965 (Figure 10) the data show a large proportion of resident in state and county, mental hospitals during the institutional phase. In 1955, hospital populations reached a little over 550,000 residents and then began to decline (Figure 10). The shift from inpatient treatment to outpatient treatment (Figure 9) began during the mid 1950s and continued during the 1960s. During this era, outpatient care episodes increased to 1.9 million episodes compared to 1.7 million inpatient care episodes (Redick et al. 1990).

Figure 10. Patients in Mental Hospitals, Psychiatric Services of General Hospitals, Private Psychiatric Hospitals and Outpatient Psychiatric Clinics from 1945-1965
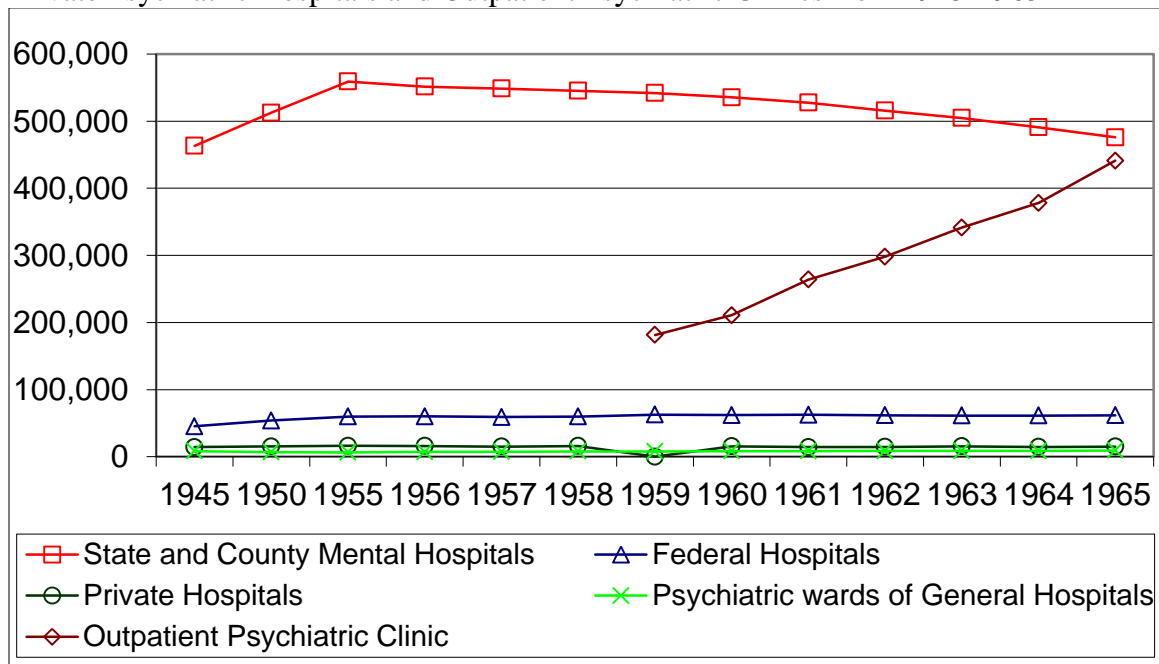
Source U.S. Census 1963-1966 and *Patients in Mental Institutions* 1947-1965 from the National Institute of Mental Health

Although outpatient services increased dramatically, inpatient services remained relatively stable from 1955 to 1965 (Figure 10). As inpatient services declined relative to outpatient services, there was a change in the way inpatient services were delivered.

Psychiatric wards of general hospitals became increasingly important during the later part

of institutional phase (Joint Commission on Mental Illness and Health 1961). Figure 11

shows the rapid growth of psychiatric wards in the numbers of hospitals for the treatment

of the mentally ill from 1945-1966. Moreover, Figure 8 shows high levels of inpatient

care episodes for both state mental hospitals and psychiatric wards of general hospitals.

These trends relate to the psychosocial model, which believes the sooner treatment was

implemented the better the outcome and treatment in the community would facilitate

better outcomes (Wilson 1993). For example, psychiatric wards of general hospitals were

used to stabilize, treat, and release patients instead of using state and county hospitals for

prolonged treatment of patients. As Dowdall (1999) describes, the focus was on avoiding

prolonged hospitalization, subsequently increasing the use of psychiatric wards in general

hospitals became an important structural component in keeping hospital stays shorter

than what had previously been considered normal.

Figure 11. Number of Hospitals for the Treatment of the Mentally Ill 1945-1966 by Type
of Hospital
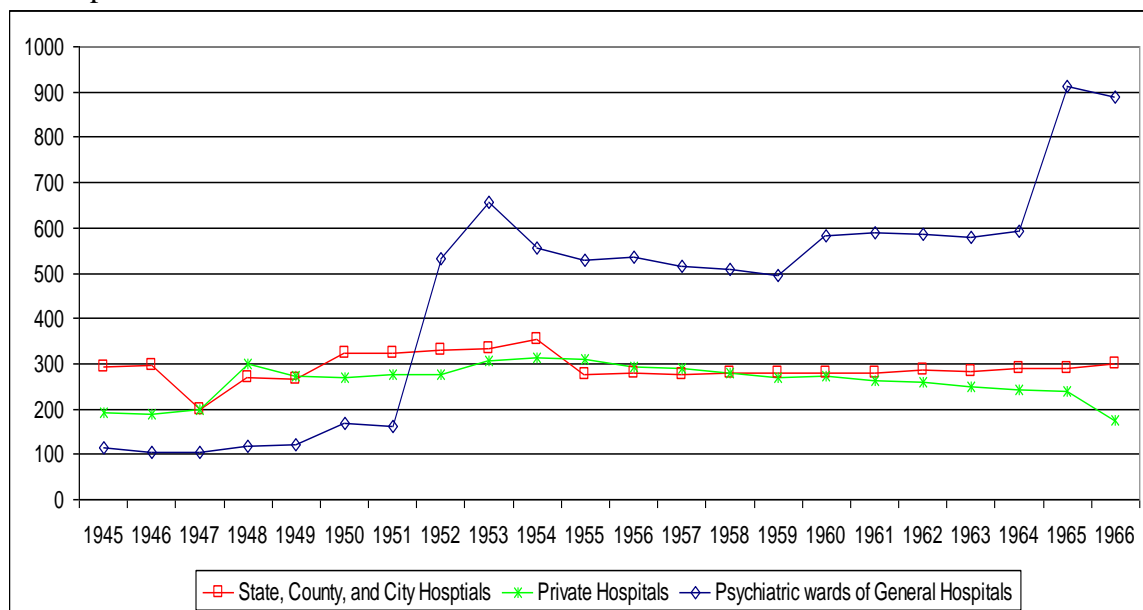
Source *Patients in Mental Institutions* 1947-1966 from the National Institute of Mental
Health

Another significant structural change was the location of treatment for patients with mental illness if patients were 65 years old or older. Figure 12 shows the dramatic increase in the population of nursing homes and the decrease in the population of state and county mental hospitals. In a report on the changing location for psychiatric services Kramer (1977) indicates that since the establishment of the Social Security act in 1935 and added amendments of Medicare and Medicaid there has been a growth in the number of nursing homes. "The number of nursing care and related homes increased from about 1,200 with approximately 25,000 beds in 1939 to 22,000 nursing and related homes with 1,202,000 beds in 1971" (35). Nursing homes had gradually replaced mental hospitals as primary locations for the care of old people with mental disorders (Kramer 1977).

Figure 12. Number of Patients over the age 65 with Mental Disorders in Long-Term Institutions for 1963 and 1969
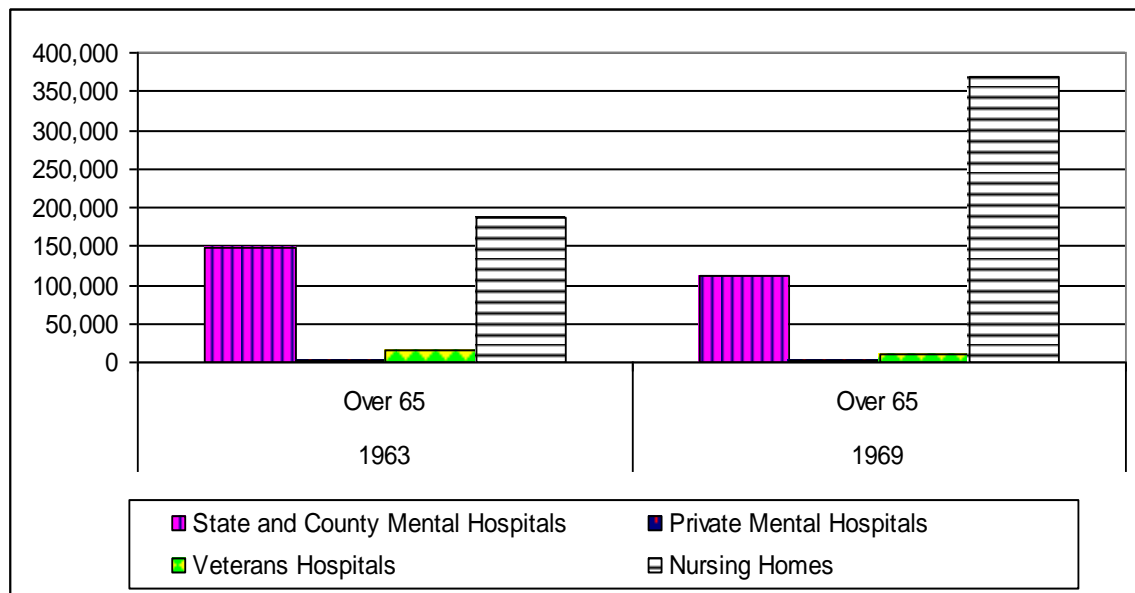
Data Source Kramer (1977) National Institute of Mental Health Series B, No. 12

At the beginning of the institutional phase, treatments for those with mental illness occurred for the most part, in large state and county mental hospitals. However, adoption of the psychosocial model, which incorporated nonpsychotic or acute forms of

mental illness, affected the types of patients, treatments, and the structure of where treatment occurred. Federal policies led to the institutionalization of new organizational forms that facilitated increased variance in the organizational fields in the mental health sector. For example, the model of care did not change until community mental health centers, psychiatric outpatient facilities, nursing homes, and insurance coverage for mental illness began to be implemented (Mechanic 2008). These new policies and organizational forms had a dramatic affect on peoples' experience of treatment for mental illness; no longer would the center of treatment be inpatient care at the state and county psychiatric hospital. If the patient did not qualify for inpatient care in a nursing home the center of treatment changed from long-term inpatient treatment toward short-term inpatient care in the general hospital and/or outpatient forms designed to keep patients in the community.

Threshold for Treatment

Another question to consider when examining the treatment career is how that career is initiated and what that process looks like when it is. This section examines the legal criterions for commitment and then discusses commitment proceedings. Exploring these decisions (legal and administrative) that guided both public and private policy for when treatment should occur, and the processes leading to involuntary treatment, demonstrates the mechanisms and structures used to treat and manage people with mental illness and their underlying assumptions.

Legal Criterion for Commitment

Important facilitators in initiating patients' treatment careers are the legal system and how it is structured to deal with persons suffering from with mental illness. Until the

mid-nineteenth century, the typical commitment process was informal; friends, family, and sometimes others could request an order for admission. However, due to reforms in the second half of the nineteenth century, commitment laws changed in order to prevent wrongful commitments (Gove, Tovo, and Hughes 1985). After these reforms, families could still bring about commitment, if they were able to pay. However, in general, if judicial and medical certification of insanity were obtained the state would assume the costs (Appelbaum 1994).

During the institutional phase, the key criterion for commitment was whether persons needed, or would benefit from treatment. This legal foundation for commitment was in place since the Civil War. Most changes in commitment law over the next century focused on the procedures associated with commitment. In response to allegations of false commitments by family members and physicians, commitment laws changed in two ways. Private facilities were subjected to more regulation and procedural safeguards were enacted that were borrowed from the criminal justice system (Appelbaum 1994). Most reform with commitment laws took on a cyclical pattern (Appelbaum 1994). For example, when the public focused on the hospitals inability to commit a person quickly, impeded by criminal-style procedures, the public pressed to do away with these procedures. Conversely, if the public attention focused on the abuse of civil liberties, greater oversight was demanded. However, none of these reforms changed the significance of central criteria for commitment, the need for and benefit from treatment (Appelbaum 1994).

An important assumption underlying the criteria for commitment was that a majority of patients would be admitted involuntarily, which parallels the chronic

conceptualization of mental illness dominant in the institutional phase. This assumption was based on the idea that mental illness undermined one's ability to seek "proper" treatment when needed, so much so, that patients would not be capable of soliciting care on their own (Appelbaum 1994). Statutes regulating emergency detention were used to restrict the number of potential patients. Detention had a different goal than hospitalization; the goal was to repress and deter conduct likely to create a danger to persons or property. Jail was used in most states to detain individuals with mental illness. Additionally, most states limited the duration of emergency detention. However, some states had no limitation (Gove, Tovo, and Hughes 1985). Typically, if states did not have medical certification procedures to commit patients, they would use law enforcement to arrest and detain persons with mental illness, pending a court hearing. Estimates in the 1930s suggest, 64 percent of patients were transported to hospitals by law enforcement and about 30 percent spent some amount of time in jail before commitment (Appelbaum 1994).

Throughout the 1940s and 1950s, medical professionals, who wanted authority to hospitalize patients by medical certification and expanded temporary commitment or observation powers, advocated new legislation. Specifically, medical professionals were critical of traditional court procedures for involuntary hospitalization, which exposed people with mental illness to public spectacle and judgment. Subsequently, state lawmakers created and implemented new legislation focusing on procedures for involuntary hospitalization and treatment, while still ignoring wrongful commitment issues (Gove, Tovo, and Hughes 1985).

By the 1960s, in the United States, states used various procedures to commit

people to mental hospitals, some states used multiple procedures. However, all states

allowed patients to be committed indefinitely (Gove, Tovo, and Hughes 1985).

Moreover, the legal justification for commitment resides in the tension between the

"harm principle—the justifications for coercion derived from the police power (to protect

society) and the *parens patriae* power (to protect the person him or herself)" (Bonnie

2001: 39). In most states, the criteria for civil commitment were whether the person was

in need of treatment or if hospitalization would benefit the person or others welfare.

However, the precise details, in most states, were not enumerated, while in other states, if

they were spelled out, they tended to grant broad powers to authorities (Gove, Tovo, and

Hughes 1985). During the institutional phase, the justification clearly leaned toward the

harm principle; however, this rationale would change.

Examining commitment histories during the institutional phase would indicate the

structure of the legal system was an important mediating mechanism facilitating the

transition from civilian to patient. From the legal perspective, patients are embedded

within a legal structure where the foundation for commitment, the need and benefit from

treatment, needed to be established. This understanding of commitment was broad and

relatively consistent for a century. Moreover, this understanding was based on the

assumption that involuntary commitment was the best mechanism to aid those in need

and a majority of patients would be admitted involuntarily. This understanding also

parallels the psychotic or chronic conceptualizations of mental illness, dominant during

the institutional phase of treatment. The foundation for commitment did not change

during this phase. This research interprets this lack of change as a consequence of the conservative nature of the law and its resistance to rapid changes.

Commitment Proceedings

Having a mental illness does not necessarily initiate one's career or engagement in treatment. Indeed, Goffman (1961) suggested the initiation of a treatment career is contingent on an interaction between the person in question and some agent, not mental illness. This section will discuss three important agents: police, family, and doctors involved in the commitment process and the process itself.

During the institutional phase most patients had a common path to the state hospital (Braslow 1997). Commitment began when someone filed a complaint of insanity against an individual, which led to a magistrate issuing a warrant for the person in question. In most cases the person in question was be incarcerated, evaluated by a court-appointed physicians, and stood trial. If the patient was committed by the court, they were then transported by the sheriff, often in restraints, to the state hospital (Braslow 1997: 18).

The police are an important agent in the initiation of an individual's treatment career. Bittner's (1967) fieldwork with uniformed police in a large West Cost city shows there are organizational and attitudinal factors involved in emergency detention of persons with mental illness, patterns surrounding emergency detention, and alternatives to emergency detention. First, the police have the statutory authorization to initiate emergency detention in a psychiatric hospital when the officer believes the person is mentally ill and presents a threat to themselves and others (Bittner 1967). However, police officers are typically reluctant to invoke this law. Several conditions typically

precede emergency detention. Emergency detention typically occurs when a suicide is or was attempted, signs of serious psychological disorder combined with a distorted physical appearance, when disorder is expressed in a "highly" agitated form, when someone is "seriously" disoriented or is creating a public disturbance. Typically, the emergency detention is based on this first hand observation by the police (Bittner's 1967). Although the police were a significant agent responsible for the emergency commitment of a large number of individuals, the police use of emergency detention was only responsible for about twenty-percent of all referrals to the public hospital in this West Cost city (Bittner 1967).

Other research points to other agents significantly related to the initiation of the treatment career. Braslow (1997) suggests the people most responsible for initiating treatment are, in this order: "relatives, doctors, police, friends, neighbors, relief home administrators, charity workers, and employers" (17). In an analysis of two mental hospitals in Massachusetts, Mishler and Waxler (1963) find that family and doctor referral are important predictors for admission to both hospitals studied. They argue, "Whether or not the referral came from a physician is the strongest variable discriminating between admitted and non-admitted groups" (584). If relatives were involved in the admission, the person in question was also likely to be admitted to the hospitals. However, in a follow up analysis of one of the hospitals, they indicate that if patients who are referred to the hospital by a physician are not admitted, they typically are not admitted to any other hospital. Conversely, patients referred by relatives, and not admitted to the hospital in question, were more likely to be admitted at another hospital in the state system (Mishler and Waxler 1963). Wilde (1968) also demonstrates the

importance of both family and physicians in involuntary admittance at a large, metropolitan public hospital in Western State. However, physician referrals were more influential. In Wilde's (1968) analysis the physician demonstrated more influence in the commitment proceedings compared to the general public.

Scheff (1964) specifies the steps in the legal procedures used to determine commitment in a Midwestern state. The process is initiated by the application for judicial inquiry, typically made by at least three citizens. Second, an intake examination was performed by the hospital psychiatrist. Then a psychiatric examination by court appointed psychiatrists was followed by the interview of the person in question by the court appointed attorney. The final step is the judicial hearing, which is conducted by a judge. Scheff (1964) asserts cases occur in this order; however, he points out that during emergencies the intake examination may come before the first step and the intake examination can occur after hospitalization. The following steps, court initiated psychiatric examination, interview with guardian *ad litem*, and the judicial hearing typically occur within a week of commitment. Additionally, Kutner (1967) and Wilde (1968), describe similar proceedings for Illinois and in a large, metropolitan public hospital in Western State, respectively.

Scheff (1964) argues that these procedures did not adequately separate those who met the requirements for commitment from those who did not. Moreover, most court decisions were perfunctory, which committed the person in question. Both Scheff (1964) and Kutner (1967) emphasize that the key element in retaining these individuals were examinations by court appointed psychiatrists. "In our informal discussions of screening with the judges and other court officials, these officials made it clear that although the

statutes give the court the responsibility for the decision to confine or release persons alleged to be mentally ill, they would rarely if ever take the responsibility for releasing a mental patient without a medical recommendation to that effect" (Scheff 1964: 405). However, there are some exceptions, as Scheff (1967) indicates. For example, a rural urban difference is noted for the influence given to medical recommendations. Metropolitan judges were more likely to accept psychiatric recommendations than the nonmetropolitan judges. He suggests time, political pressure, psychiatric sophistication, and lack of personal familiarity with patients and their family were the likely cause for the differences between accepting psychiatric recommendations in the two separate locations (Scheff 1967).

The literature on commitment proceedings indicates the importance the family, police, and physicians have in the initiation of an individual's treatment career. These groups are agents that use the existing legal structures to manage people with mental illness. These structures are based on assumptions about what mental illness is and how it is best treated. During this phase of treatment the legal structure was closely related to the chronic or serious conception of mental illness. As a result of this conception, the best method for initiating treatment was understood to be involuntary commitment. For example, the literature on commitment proceedings shows the importance of the various agents. Goffman (1961) argues from patients' perspective, suggesting that patients are subjected to "the betrayal funnel," which leads to involuntary commitment to a hospital. What is important in this process is the structure available to key agents: family, police, and physicians. Agents must use the structure at hand. Once this structure is developed it reifies the conceptualization of mental illness and mental disorder. Therefore, existing

structures are based on current conceptions about what mental illness is and how it is best treated. They do not change until the conception of mental illness and treatment are changed.

Patient Release

An important question to ask in order to understand patients' treatment careers is how they are released from treatment. Rock, Jacobson, and Janopaul (1968) suggest there are two ways for terminating commitment in a large state or county mental hospital, administratively or judicially. Administrative discharges, in which hospital superintendents authorized discharges, constitute the majority of discharges and were based on a medical determination about the need for further treatment. The standards for administrative discharges are broad and ambiguous. Thus, any patient who is thought to have recovered, improved, or is even unimproved can be released, as long as the discharge will not endanger the patient or the public. Patients can also be conditionally released while the hospital technically retains custody, which is done so there is no need for a new commitment hearing.

Administrative discharges were not practiced uniformly throughout the institutional phase. The only thing consistent was the need for superintendents to approve discharges. However, this power was typically delegated to the ward doctors, who developed their own methods for determining discharges (Rock, Jacobson, and Janopaul 1968). One hospital allowed patients to request a vote to determine if they were eligible for release. Patients were evaluated by other patients on the ward at a patient government meeting and their peers would determine their eligibility for release. Some institutions implemented a more formal procedure similar to a judicial hearing. They required any

discharge be approved at a staff meeting. The ward doctor initiated the hearing, prepared and presented a summary of the patient's case and emphasized factors indicating the patient were ready for discharge. Then the patient was questioned, then dismissed and the case discussed and a decision is rendered. The most common form of determining discharges involved no hearing; it was simply determined by the ward doctor. The ward doctor wrote an order, and although the staff could participate in the conversation, the doctor made the decision. Patients, their family, or another party could have asked doctors consider a release, this, however, was not obligatory (Rock, Jacobson, and Janopaul 1968).

Judicial discharges (when courts would order a patients release) constituted a small number of discharges (Rock, Jacobson and Janopaul 1968). The volume of cases that were directly affected amounted to about three to four a year in most institutions studied. This was because of the broad authority of hospitals and the hospitals willingness to release patients. The superintendent has the final say as to whether or not the hospital opposes any judicial release. The authors suggest illegal detentions in public hospitals were not a problem, because the hospitals were so overcrowded. If there were any curiosity shown towards a patient, the hospital would discharge them, even though they could still be suffering from symptoms of mental illness. Additionally, if a family insisted a patient should be discharged before the doctor agrees, the patient would be discharged with an understanding that the family would take responsibility. One exception to the judicial discharge was the belief the patient is still a threat to themselves or others. Thus, judicial discharges had more of an indirect effect rather than a direct effect on discharge

patterns and more patients were discharged because they asked for judicial

determinations instead of receiving them (Rock, Jacobson and Janopaul 1968).

Over the twenty years of the institutional care phase discharges from state and

county mental hospitals increased. Heckel et al., (1973) argue that a large number of first

admissions have a terminal point in the hospital they studied. For example, their data

suggest many will be discharged within the first three months of admission; however, the

majority will be discharged within the first six months. Compare this finding to

Belknap's finding in (1956) that about half of cases are furloughed or discharged form

the hospital after a year. Although these researchers were examining different hospitals,

in different states, this research gives us an idea that release rates changed over time,

which Figure 13 shows.

Figure 13 demonstrate how discharges and admissions in state and county

hospitals have changed from 1945-1965. Moreover, Figure 13 shows discharges from

hospitals over the twenty-year period increased dramatically compared to admissions,

which increased, more slowly. These discharges also mirror the change in the

conceptualization of mental illness and structural changes. That is when changes in the

conception occurred this changed the patient characteristics from more chronic disorders

to more acute forms of illness. The structural changes were designed to bring in more

acute forms of mental illness, treat them, and then release them, which led to a higher

turnover compared to chronic forms, which would require longer periods of treatment.

Figure 13. Yearly First Admissions and Discharges (not including deaths) for State, County, and City Hospitals from 1945-1965
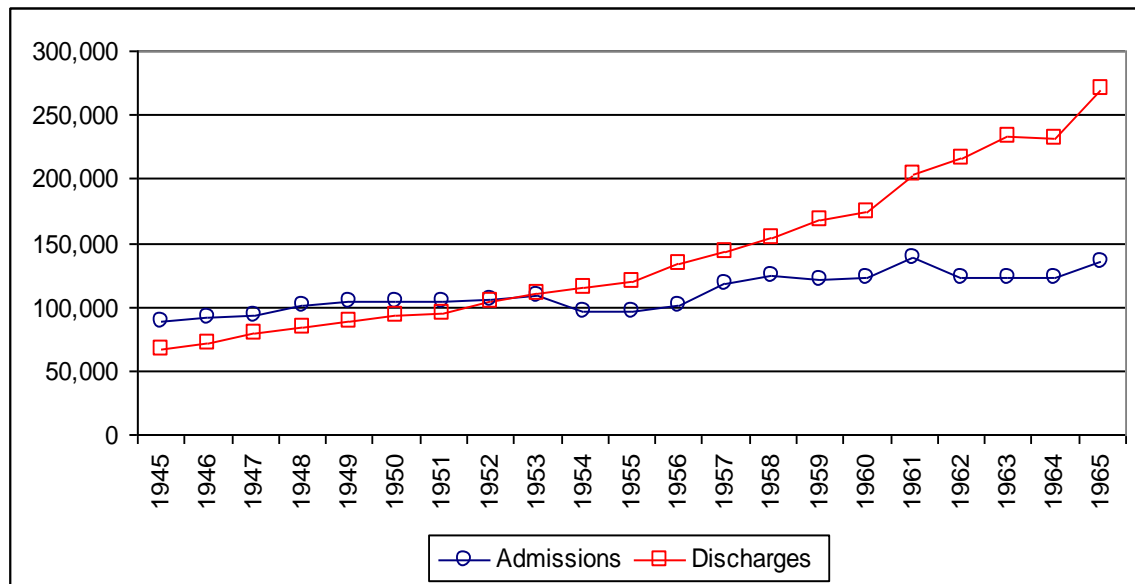
Source *Patients in Mental Institutions* 1947-1965 from the National Institute of Mental Health

In summary, administrative procedures were responsible for more discharges than judicial hearings. However, judicial hearings proved to be a check against unwarranted commitment. The courts threshold for release influenced the administrative threshold for release, which was whether they were dangerous to themselves or others. However, discharges were influenced more by conceptual and structural changes than by legal or administrative changes. For example, as the conceptual understanding of mental illness changed from psychotic or chronic to nonpsychotic or acute forms of mental illness, who psychiatrists understood as mentally ill changed. This change screened patients and more acute forms of mental illness began to be the emphasis of treatment compared to chronic forms of mental illness.

The Institutional Pillars

In terms of neoinstitutional theory, during this phase understanding of mental illness as psychotic or chronic was a cultural-cognitive element of the medical institution.

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The cultural-cognitive element represents shared frameworks, within an institution, that are used to create meaning (Scott 2008: 57). Neoinstitutional theory emphasizes the collectively mediated creation of widespread frameworks of meaning.

First, this analysis suggests the understanding of mental illness has changed over time. An important theme to this change is an increasing delineation of symptoms into different categories of disorder. This is apparent from the use of the 1840 U.S. census single category of "insane and idiotic" to the development of the twenty-two categories of mental illness in the *Statistical Manuel for the use of Institutions for the Insane* (1918) to the expansion and addition of disorders in *Diagnostic and Statistical Manual of Mental Disorders* (1952). However, what remained consistent, at least from 1918 until World War II, was the use of the cultural-cognitive frame (Kraepelinian model) where understandings of mental illness were psychotic or chronic, as represented by types of diagnoses. After World War II, with the implementation of the psychosocial model, mental illness began to be understood differently. As Wilson (1993) argues, the psychosocial model became the dominant perspective in post war years.

Next, the cultural-cognitive frame used to understand mental illness played an important role in determining which treatments and locations are desirable and legitimate, which affects the normative pillar of the institution. The normative pillar of an institution consists of values and norms, which help define what is desirable and legitimate for institutional objectives (Scott 2008). Although types of treatment varied during the institutional phase they consistently focused on "control" over patients. Water treatments, shock therapies, lobotomies, to psychotropic drugs were all compared to the use of physical restraints. When the cognitive frame used to understand mental illness changed,

the length of treatment and the need for controlling methods, while still used, became less important. Subsequently, the psychiatric discipline emphasized environmental factors, which were thought to add to or "cause" psychiatric problems. Thus, the interaction between the cultural-cognitive and normative pillars created a new institutional logic. This is exemplified in the transition in the institutional logic from institutional care to community-based care.

Finally, changes in cultural-cognitive and normative pillars led to changes in the regulative pillar of the mental health sector. During this phase, a number of policy acts reshaped the structure and treatment of mental illness. Without these policies and funding to create new structures and treatments, the treatment career of those with mental illness may not have changed. The change in the cultural-cognitive perspective influenced changes in the normative and then the regulative systems regarding the care and treatment for the mentally ill. In this particular case, the discipline of psychiatry, initially the actor, whose understanding of mental illness (their cognitive framework) helped structure the types of patients, types of treatment, treatment location, the threshold for treatment as well as when patients ended treatment.

Institutionalization

This process is exemplified in the creation and institutionalization of a new organizational form of treatment, the community-based model of care. Tolbert and Zucker (1996) provide an important framework for understanding the institutionalization process: they first suggest that actors innovate when responding to political, technological or market conditions. In addition to these three stimuli, this review would suggest, because of the crisis generated by the Great Depression and World War II, actors came to

realize neuropsychiatric disorders were a larger problem than previously thought, consequently, actors began to innovate. This would suggest, in general, that innovation comes from multiple indicators, which represent larger environmental stress or change. For example, Grob (1991a) argues the organizational and conceptual changes in psychiatry may not have amounted to much had their not been larger forces at work. He argues the historical context following the Depression and World War II legitimated the welfare state, increasing federal activities in the provision of health care, and legitimated the employment of scientists and intellectuals to create and implement policy. All of these factors were part of the broader cultural context, which facilitated the promotion of federal solutions to larger social problems. Given this context, the new psychiatric framework was used to help reshape public policies and public feelings about mental illness.

Next, Tolbert and Zucker (1996) suggest the process of habitualization occurs, which involves organizations incorporating new structural arrangements because of environmental stimuli, some of these innovations are retained and become accepted and habituated, whereas others do not. The habitualization stage occurred during World War II, when actors, military psychiatrists, came to realize that early treatment outside of institutions would generate better results when treating combat stress. The innovation and habitualization phases are considered the pre-institutionalization stage.

The organizational form becomes institutionalized during the objectification phase, which involves a social consensus among the elite decision makers of organizations, who pass judgment on the organizational form; in this case, the elite were shaping policy that affected the creation of the new organizational forms. This social

consensus bestows value on the structure and increases organizational adoption. Tolbert and Zucker (1996) suggest two mechanisms used to generate this consensus. First is the use of evidence to assess the dangers involved in adopting the new form. Second is a "champion", who is a person or persons who advocate for structural change in organizations. Robert H. Felix, William Menninger, Francis Bracland and Jack R. Ewalt made up the Group for the Advancement of Psychiatry, which was the progressive arm of the American Psychiatric Association (Kirk 1999) and these were the "champions" of the new organizational structure being institutionalized, the community-based model of care.

Specifically, they were instrumental in creating and running the NIMH, which was the federal agency that advocated for the community-based model of care. As discussed in the section on deinstitutionalization, in 1946, the National Mental Health Act established grants to states, to create outpatient facilities and short-term inpatient facilities. Another act was the Mental Retardation and Community Mental Health Centers Construction Act passed in 1963, which provided federal monies for construction and staffing of Community Mental Health Centers (CMHCs). The federal government developed additional programs to keep mentally ill people economically independent and in the community such as Medicaid and Supplemental Security Income (SSI) and the expansion of Social Security Disability Insurance (SSDI). What is crucial about these regulative acts are they served as coercive mechanisms by providing streams of revenue, which created infrastructure that undermined the role of the state and county mental hospitals.

Finally, Tolbert and Zucker (1996) argue the process of institutionalization occurs over time and place. The sedimentation of the organizational form is "a process that

fundamentally rests on the historical continuity of structure, and especially on its survival across generations of organizational members" (184). This sedimentation is documented with the increased use of outpatient forms of treatment over time in Figure 7 and Figure 8.

Both the desirability and legitimacy of treatment and its location began to change because the cultural-cognitive framework used to understand mental illness changed too. The structure of where treatment occurred began to change from inpatient facilities to locations in the community. This is apparent in Figure 6, Figure 7, and Figure 9, when the number of inpatients begins to shift to general hospitals with psychiatric units, the number of patient in outpatient psychiatric clinics increases, and the number of general hospitals with psychiatric units increase. Despite these trends showing the institutionalization of the community-based model of care, the process of deinstitutionalization, although beginning, was still in its early stages throughout this phase and not easy to observe.

While the important development during this treatment phase was the re-conceptualization of mental illness, the state mental hospital was still the most important player in the treatment for those with mental illness, and did not appear to be going anywhere. What initially changed were the types of patients being treated in the state and mental hospitals. Figure 2, shows the increasing admission of those patients being designated as having nonpsychotic disorders and Figure 13 shows the increasing number of discharges compared to admissions, which started long before the criteria for involuntary commitment changed. Nevertheless, this increase in discharges suggests

nonpsychotic or acute forms of mental illness would be brought in, stabilized, and then released, leading to higher turnover rates.

From this analysis, we can see the importance of the cultural-cognitive, normative, and regulatory pillars in the stability and change of an institution. These pillars play an important role in both whether and how individuals with mental illness experience treatment. The conception of mental illness has consistently changed over time; however, with World War II the importance of nonpsychotic or acute disorders came to the forefront of psychiatry. Following this change was the changing desirability and legitimacy around the types and location of treatment. With these conceptual and normative changes—nested within the larger historical context of the Great Depression and World War II, which led to the elevated perception of Federal intervention—polices were created that re-structured how people with mental illness receive treatment. What this analysis suggests is the cultural-cognitive framework used to understand the specific social problem that an institution deals with is the foundation for institutional stability or change of its structures.

Conclusion

When examining the treatment career of a mental patient, it is important to consider how the profession orders the nosology of mental illness, which has a profound impact on treatment careers. During the latter part of the institutional phase, from 1945-1965 how mental illness was classified—the cultural-cognitive frame—began to change. This had important implications for how the mental patients' treatment career unfolded. Because of larger changes in society, the idea of what mental illness is and how it was classified went through dramatic changes, which influenced the idea of how to treat

mental illness. Consequently, mental illnesses considered important during the institutional phase were different from what subsequent generations would consider important.

An important example of how the classification of mental illness changed is the consequences this had on patients' characteristics. Two important characteristics that changed over this phase were the chronic/acute or psychotic/nonpsychotic dichotomy and the age of mental patients. For example, when the understanding of mental illness as psychotic or chronic types of illness changed to incorporate nonpsychotic or acute forms the number of nonpsychotic or acute patients and younger patients receiving treatment increased in the state and county mental hospitals.

Treatment of mental illness also reflects classification schemas of mental illness. Various forms of treatment were popular before the conception of mental illness changed. The various forms of treatment; however, indicated physicians' conceptualization of mental illness centered on chronic understandings, which emphasized "control" over patients in a physical location. This indicates changes in treatment did not deviate from the conceptualization of mental illness as psychotic or chronic until the conception of mental illness changed towards a more acute understanding. When this change transpired, the emphasis changed from controlling methods in a physical space to less controlling methods of treatments located in the community.

Along with treatment, location of treatment was also influenced by how mental illness is classified. During the institutional phase, treatments for those with mental illness occurred for the most part, in large state, and county mental hospitals. However, as the professional conception of mental illness changed, from psychotic or chronic to

nonpsychotic or acute forms of mental illness, towards the end of the institutional phase what becomes evident is this affected both the types of patients, the forms of treatment, and the structure of where treatment occurs, mediated by Federal policies that facilitated institutionalization of a new organizational forms to provide a community-based care. The center of treatment now began to change from long-term inpatient care to short-term inpatient care and outpatient forms designed to keep the mentally ill in the community.

Conceptualization of mental illness was also important for the legal criterion for commitment. During the institutional phase, the key criterion for commitment was whether the person in question needed or was likely to benefit from treatment, which was used for over a century. It was assumed that most patients would be admitted involuntarily, which parallels the chronic understanding or conceptualizations of mental illness, dominant in the institutional phase. Moreover, the foundation for commitment did not change during this treatment phase, when professional taxonomies changed, it stayed consistent and reflected previous generations understanding of mental illness.

The literature on commitment proceedings also indicates the classification of mental illness influenced the treatment career. Commitment proceedings indicate the importance of key agents on the initiation of an individual's treatment career. These agents used the existing legal and administrative structures to handle people with mental illness. But key agents could only operate with the structure at hand and once this structure was developed it enforced current conceptions about what mental illness was and how it was best treated.

Discharges also reflect the change in the conceptualization of mental illness. As first admissions to mental institutions began transitioning from patients with psychotic or

chronic conditions to more nonpsychotic or acute condition discharges began to increase. This suggests when the conceptualization of mental illness changed state and county hospitals saw more acute forms of mental illness, which were brought in, stabilized, and then released. This had the effect of leading to higher turnover rates than when more patients with chronic forms of mental illness were emphasized.

In conclusion, this chapter shows the importance of the cultural-cognitive framework used to understand the specific social problem (i.e., mental illness). This understanding is the foundation for institutional stability or change of the organizational structures and the roles people assume within the organizations. Professional conceptualizations of mental illness have a profound impact on treatment careers. This is exemplified by changes in the category of mental illness more likely to receive treatment, types of treatment, its location, the legal criterion for commitment, and discharges. Neoinstitutional theory shows the importance of understanding the cultural-cognitive framework used to conceptualize a social problem and is critical to understanding the mental illness career. The change in cultural-cognitive framework had consequences for both the normative and regulative aspects of the institution, which led to the creation and institutionalization of a new institutional logic, the community-based model of care. The use of neoinstitutionalism to frame the mental illness career helps us understand that the change in the cultural-cognitive perspective influences changes in both regulative and normative systems regarding the care and treatment for the mentally ill.

Chapter 5. The Mental Illness Career during the Community-Based Care Phase

This chapter covers treatment careers of people with mental illness during the community-based care phase from 1965-1985. As in the previous chapter, changes in the organizational field and the effects on mental illness careers, are explained using a modified version of Gove's (2004) framework. This allows the mental illness career to be understood within organizational context and change. This chapter will first focus on the socio-political-economic and historical context of this phase. Then, it will consider who was seen as mentally ill during this phase, which requires an understanding of how mental illness was classified and patient characteristics important for treatment. Next, the chapter focuses on treatment practices and organizational forms used to treat individuals with mental illness. An understanding of the practices and structures used to treat people with mental illness during this phase demonstrates the consequence of organizational context and change on patients' treatment careers. Then, it examines why treatment begins and ends for people with mental illness. Finally, this chapter concludes with an explanation of the mental illness career during the community-based care phase through the lens of neoinstitutional theory allowing for the interpretation of consequences that organizational context and change have on patients' treatment engagements and their subsequent treatment careers.

Socio-Political-Economic and Historical Context of the Mental Illness Career

Until the late 1960s and early 1970s, the medical community was granted a broad mandate to run their own business matters; however, like many other institutions, medicine and experts running these institutions, lost public confidence. There was a broad public shift from the focus on scientific progress in medicine to one that was more

oriented toward moral and economic problems. First, moral concerns were raised about the medical community abusing its power. These concerns suggested patients' rights needed to be protected (Star 1982). Second, new economic concerns engendered criticisms against federal programs supporting community-based care (Kenig 1992).

The country was dealing with inflation and economic stagnation that could not be relieved by standard Keynesian economic policies implemented during and after the Great Depression and World War II. This era is known and understood to scholars as "Post Fordism" (Sewell 2005). Post Fordism created a new socio-political-economic and historical context that undermined the legitimacy of institutions and the experts running those institutions. Both institutions and experts came under increasing scrutiny by various groups. As costs increased in health care, the federal government and private third-party payers increasingly intervened in doctors' treatment practices (Star 1982). This intervention changed not only how doctors practiced but also how patients engaged in treatment.

However, changing soci-political-economic and historical context occurred during a time when the institutional logic made the final transition from institutional care to community-based care through deinstitutionalization. Deinstitutionalization transferred the location of care from state hospitals to communities. However, community-based institutions emerged unprepared, without a clear understanding of new challenges posed by deinstitutionalization (Kenig 1992; Rosenberg and Rosenberg 2006). The fundamental problem with community-oriented policies was the assumption that the public would welcome people with mental illness back into the community (Grob and Goldman, 2006). These flawed assumptions, coupled with increasing economic scrutiny on the methods of

treatment, had important implications for individuals' abilities to receive continuous and

effective treatments. Almost from the outset, the community-based care treatment

phase—from 1965-1985—began transitioning toward an ambiguous system.

Categorizing Mental Illness

As discussed in the previous chapter, the development and implementation of the

psychosocial model of mental illness had enormous implications for the treatment career

of those with mental illness. Coming out of World War II, the psychosocial model

viewed individual psychological processes and environmental conditions as interacting to

create mental disorder (Wilson 1993). The DSM-I, best illustrates this model where all

"functional" disorders were considered individual reactions (Grob 1991b; Wilson 1993).

This understanding broadened the definition of mental illness and confused the boundary

between mental health and illness. According to this model, the distinction between

health and illness was secondary to understanding the meaning of the symptoms (Wilson

1993). However, the understanding of mental illness as reactions to psychosocial causes

and the diagnostic linkage to debated etiological explanations were changed with the

DSM-II and seemed to anticipate the nosologic changes coming in the DSM-III (Rogler

1997).

The psychosocial model blurred the boundary between mental health and illness,

which expanded the role of psychiatrists in the public sphere (Horwitz 2002b, Wilson

1993). First, the psychosocial model emphasized to the role that family life, poverty, and

racial discrimination had in pathology and sought solutions. Second, social activism was

encouraged during the 1940s and 1950s, which led to the community mental health

movement. The community mental health movement sought to transfer treatment from

long-term hospitals to local community hospitals, clinics, and private practitioners. However, this social activism engendered resentments by biologically oriented psychiatrists, sociologists, and third-party payers which threatened the relevance and legitimacy of psychiatric treatment. By the late 1960s, the psychosocial model was under strong attack from multiple sources (Wilson 1993).

First, biologically oriented psychiatrists advocated returning to more of a medical model of mental illness. The world-changing mission of social activists in psychiatry was viewed as misleading the discipline and endangering its ability to treat people with mental illness by delegitimizing psychiatric arguments. They were frustrated with the lack of progress in research under the psychosocial model and were discouraged by psychiatry's drift away from medicine (Wilson 1993). When the development of the psychosocial model transpired the typical method for medical research was case histories; however, these histories lost favor among medical researchers. This was problematic for a discipline that lacked legitimacy among its medical peers. Moreover, the standards for medical research changed, which created further pressure to conform to a biologically oriented practice (Horwitz 2002b).

In addition to this attack, American psychiatry's leading role in the mental health care institution was questioned (Kirk and Kutchins 1992). There were two reasons for doubt. First, psychiatry was successful at promoting the community mental health movement and outpatient psychotherapy, when third-party money became available for treatment it came with increased competition. Competition came from disciplines such as psychology, social work, nursing, and marriage and family counselors. Moreover, when treatment practices followed the psychosocial model and were practiced in the

community by different types of professionals, mental health treatment became "less medical" and undermined the role of the physician in mental health care. Second, within the medical profession psychiatry had a marginal status. Using the psychosocial model psychiatrists often provided services that were supplied by nonmedical professionals. From a scientific perspective, therapeutic methods and outcomes were unproven (Kirk and Kutchins 1992).

Another attack on the psychosocial model came from outside psychiatry from sociologically oriented actors. This attack centered on the idea that mental illness was not the territory of medicine, because the psychosocial model defined mental illness not as medical but social. These attacks focused on the uncertain boundary of mental health and illness, which suggests that diagnoses were arbitrary and capricious. Moreover, because no causal mechanisms were determined, mental illness could not be considered a disease (Wilson 1993). Taken together these challenges threatened psychiatry's monopoly over knowledge and increased the likelihood of "deprofessionalizing", which is when a profession loses its unique qualities that justify its existence (Turner 1990). Biologically oriented psychiatrists proposed dealing with mental illness using the classical medical model (Wilson 1993) to recapture psychiatry's monopoly over specific knowledge.

Paralleling these attacks on and threats to American psychiatry, came increased concern from third-party payers of services. The psychosocial conception of mental health and illness was fluid, which created problems determining criteria for treatment. In the 1960s Aetna and Blue Cross underwrote The Federal Employees Health Benefits Program. They initially reimbursed treatments for mental illness dollar for dollar along with other medical problems; however, this was cut back. Both the federal government

and private insurance companies saw mental health reimbursements as a never-ending outflow of income because it lacked standardized diagnosis and treatment methods (Wilson 1993). Another reason third-party payers gained more voice in the mental health sector was that federal funding for community mental health centers was reduced during the 1970s and into the early 1980s (Kenig 1992). These third-party payers began to require a closer relationship between diagnosis and treatment (Kirk and Kutchins 1992).

Finally, with the introduction of pharmacological solutions for specific psychiatric syndromes, the idea that drugs were more effective and could target discrete symptoms was becoming more popular (Wilson 1993). This new treatment supported the claims of biologically oriented psychiatrists, who viewed mental illness as biological in origin and undermined psychosocial arguments against psychoactive drugs (Horwitz 2002b). When applied to more severe cases of mental illness biologically oriented psychiatrists questioned psychotherapy's efficacy. Psychotherapy's main form of treatment was not as easily distributed as other treatments (Wilson 1993). Additionally, Horwitz (2002b) asserts the Food and Drug Administration (FDA) forbade drugs to come to market if they were not shown useful for specific disorders. This also helped bolster those using the biological or Kraepelinian assumption that disorders are discrete entities and undermined the psychoanalytic conception of mental illness as a continuum. These factors helped create for a more medically based psychiatry, which would have explicit inclusion and exclusion criteria for a diagnosis (Wilson 1993).

These problems came to a head in the early 1970s when two prominent cases called into question the legitimacy of the psychiatric profession: one was the controversy over the diagnosis of homosexuality. The resolution of this problem—striking

homosexuality form the DSM-II—was viewed more as a political as a scientific

resolution and brought more questions about psychiatric diagnoses (Kirk and Kutchins

1992; Wilson 1993). The second included Rosenhan's (1973) study inwhich "normal"

people who pretended to have psychiatric problems were admitted to hospitals. The study

called into question the reliability and validity of psychiatric diagnosis (Kirk and

Kutchins 1992; Wilson 1993).

Subsequently, in the 1970s, psychiatry tried to respond to these critiques, criticize

the psychosocial model and its troublesome consequences, as well as defend the medical

model (Wilson 1993). This attempt came in the form of the DSM-III task force, headed

by Robert Spitzer. Spitzer and a small group of likeminded colleagues produced the first

draft of the DSM-III within a year (Kirk and Kutchins 1992; Wilson 1993). According to

Kirk and Kutchins (1992), while it would take five more years to publish the manual "the

essential decisions about its approach, structure, and contents were made quickly by

Spitzer and this small group" (99). From the beginning, this task force was working from

the guiding principles of descriptive psychiatry, which suggests disorders should be

narrowly defined. This perspective reoriented the understanding of mental illness. For

example, the task force agreed that "functional" did not adequately describe any type of

disorder. Moreover, the concepts of psychosis and neurosis could not be used to classify

any type of disorder; however, they could be used as adjectives (Wilson 1993).

During this phase, the emphasis transitioned from understanding the meaning of

symptoms, as in the DSM-I and II, to describing mental illness in the DSM-III. For

example, the DSM-II housed 182 specific disorders in fewer than 40 pages, whereas the

500 page DSM-III housed a third more, with 265 disorders listed (Kirk and Kutchins

1992). Children's disorders expanded the most. The majority of the new DSM text described these specific disorders and identified specific symptoms, which were listed. The DSM-III shifted the balance of power in American psychiatry from those who understood mental illness though the psychosocial framework to those using a descriptive nosology. Whereas the DSM-I was about a large groundswell of psychiatrists wanting and needing a better way to understand and treat mental illness in response to World War II, the DSM-III was an internal "revolution" by those few champions who took it upon themselves to resolve a crisis of legitimacy, which reified a more precise conceptualization of mental illness.

The DSM-III provided psychiatry with a common language to communicate and map its professional domain (Wilson 1993). It has arguably advanced treatment of some disorders, such as major depression, bipolar disorder, and anxiety disorders. This narrowing has changed the way mental illness is conceived (Wilson 1993: 408). The DSM-III resolved the crisis of legitimacy that the psychiatric discipline was going through and enabled the discipline to regain its legitimacy (Horwitz 2002b; Kirk and Kutchins 1992; Wilson 1993). Additionally, the purported difference between the previous DSMs and the DSM-III was the DSM-III's alleged "atheoretical" stance with regards to etiological explanations. However, according to Rogler (1997), this coexisted with the fact that biological explanations of mental illness were more compatible with observational theories (Rogler 1997: 12). As with the change that occurred during World War II, this conceptual shift affected how different people with different types of disorders (brain impaired, psychotic, and nonpsychotic) experienced treatment.

Patient Characteristics

As in the institutional treatment phase the changes in conceptualization of mental illness resulted in changing patient characteristics within various organizational types. When the data permits, this chapter delineates mental disorder into three categories: brain impairment, psychotic disorders, and nonpsychotic disorders. As discussed in the previous chapter, patient characteristics were important for their treatment careers. However, during this phase of treatment, the state and county mental hospital lost its dominate role in the inpatient treatment of those with mental illness and other organizational types became more important in mental health treatment career. General hospitals and nursing homes became the site of inpatient hospitalization and outpatient psychiatric services were used with increasing frequency, during this treatment phase.

The decline in resident patients from state and county mental hospitals is demonstrated by data from the National Institute of Mental Health (Figure 14). Figure 14 shows the total resident patients in state and county mental hospitals by the type of disorder from 1950 to 1985. Figure 14 shows who made up the majority of the residents for hospitals and how they emptied. First, the majority of residents fell into the psychotic category, followed by those with brain impairment, until the late 1970s. From 1950 to 1960, total growth rates tended to increase; however, after 1960 the state psychiatric hospitals began to empty. At first, the hospital emptied slowly; from 1960 to 1965 the growth rate decreased by only 2 percent, suggesting little change.

However, from 1965 to 1970 the data indicate that brain impairment and psychotic disorders decreased dramatically, with negative growth rates of -36 percent and -29 percent, respectively. This decrease, in large part, would have to do with the

introduction of Medicaid and Medicare policies and the coercive isomorphic forces these

policies brought to bear on the institution of mental health. Moreover, these policies

allowed states to shift some of the mental health treatment costs to Federal programs.

Juxtapose these growth rates with nonpsychotic disorders, which continued to increase,

with a growth rate of about 56 percent. Though after 1970 all disorders decreased (Table

2), showing the decreased use of state and county mental hospitals for residential

treatment (Figure 14). As Geller (2000) argues a majority of the decrease in the size of

patient population in the state and county hospitals was a result of patients' length of

stays shortening.

Figure 14. Total Number of Resident Patients in State and County Mental Hospitals at
End of Year and by Type of Disorder 1950 to 1985
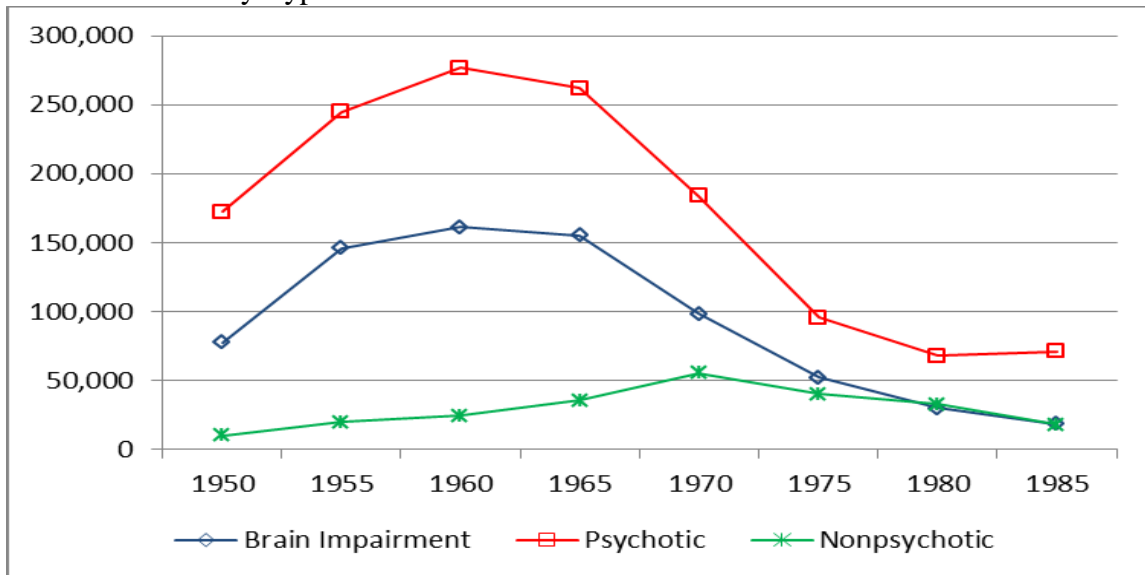
Source *Patients in Mental Institutions* 1947-1965 and *Mental Health*, United States 1985
from the National Institute of Mental Health

Table 2. Growth Rates of Patients in State and County Mental Hospitals at End of Year by Type of Disorder

Year	1950 to 1955	1955 to 1960	1960 to 1965	1965 to 1970	1970 to 1975	1975 to 1980	1980 to 1981	1981 to 1985
Brain Impairment	88.33%	10.51%	-3.83%	-36.54%	-47.18%	-42.28%	-15.41%	-27.32%
Psychotic	42.01%	13.10%	-5.45%	-29.83%	-48.05%	-28.70%	9.17%	-4.20%
Non-psychotic	93.71%	25.40%	44.62%	56.15%	-27.56%	-19.03%	-24.52%	-27.16%
Total Growth Rate	57.82%	12.77%	-2.23%	-25.38%	-43.31%	-30.22%	-5.38%	-12.99%

A significant trend was the development of state hospital programs which were designed to reintegrate patients into the community and secure a role for the state mental hospital in the treatment career of patients' with mental disorders during these turbulent times (Geller 2000). These programs proliferated during the 1960s where "the leaders of state hospitals were busy redefining the role and designing the functioning of state hospitals to ensure the hospitals' future existence" (Geller 2000: 46). Specifically, state and county mental hospitals attempted to structure themselves around patients with nonpsychotic disorders. Figure 15 shows that between 1965 and 1970, there was a substantial increase in the number of nonpsychotic patients who were residents. The trends of increasing numbers of nonpsychotic patients and the development of state hospital programs designed to reintegrate people into the community (Geller 2000) is important. These trends are interpreted as the leaders of state hospitals reacting to the deinstitutionalization process and the subsequent community-based care movement by shifting the treatment focus towards nonpsychotic patients.

This shift in focus was the culmination in the community-based care movement and is reflected in the changing importance of patient characteristics as indicated in

Figure 2 and Figure 15 within the state and county mental hospitals. It was not until the 1970s that debates about closing state hospitals came to the fore. Although state hospitals became more integrated into the community during this time, potential patients began to be rejected for services by the state hospitals. This shift in focus from psychotic to nonpsychotic led some to worry that the "popular" trend was to spend money on community programs, which were inadequately designed for those with psychotic disorders (Geller 2000). An insight that proved true.

As indicated above, the full force of the changes in the cultural-cognitive conceptualization of mental illness during the institutional care phase were not felt until the beginning of the community-based care phase. However, the psychosocial conceptualization of mental health did not last. During the later part of the community-based care stage the conceptualization of mental illness changed again. However, this change was also expressed in changing patient characteristics. First, the implementation of the DSM-III reversed two prominent trends in percent of resident patients by type of disorder in state and county mental hospitals. From 1965 until 1975 the percent of psychotic patients who were residents of state and county mental hospitals decreased and leveled off from 1975 to 1980. Moreover, the percent of nonpsychotic patients increased from 1965 until 1980. These two trends reversed course after the implementation of the DSM-III occurred (Figure 15). Moreover, Table 2 shows psychotic disorders had a 9 percent growth rate from 1980 to 1981, the first year DSM-III diagnostic groupings were used. Finally, since 1965 those with brain impairments continued to decrease as a percent of residents in state and county mental hospitals, with no change despite the new conceptualization (Figure 15). There is little doubt that the introduction of Medicare and

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Medicaid facilitated and sustained this consistent decrease in brain impairment cases over this phase of treatment, which were transitioned to other organizational forms.

These findings suggest after implementing the DSM-III and the Kraepelinian model psychotic disorders regained their importance within psychiatry's cultural-cognitive conceptualization of mental illness. Nonpsychotic disorder began to loose their importance. Although psychotic disorders began to occupy a larger role in treatment, this did not reverse the structural changes that state and county mental hospitals were going through and despite a small uptick in 1981 of psychotic disorders, the general trend of deinstitutionalization continued. Subsequently, because deinstitutionalization fragmented treatment, further investigation is required to understand how changes in conceptualization affected patient characteristics and treatment within other organizational forms.

Figure 15. Estimated Percent of Resident Patients at End of Year in Public Mental Hospitals by Disorder Type 1965 to 1985
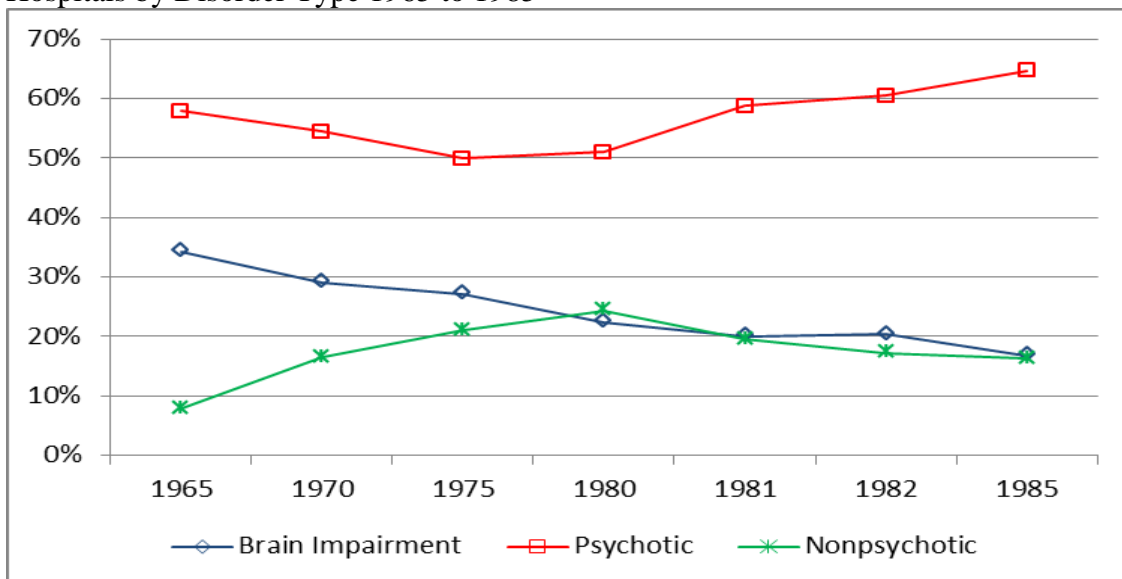
Source: *Patients in Mental Institutions* 1947-1965 and Data from National Institutes for Mental Health 1970-2005

Figure 16 and Figure 17 show total admission for private and psychiatric wards for general hospitals by type of disorder throughout the 1970s. Total admissions show first admission, re-admission, and transfers to specific facilities in the figure. These figures show some changes: Patients with psychotic disorders represented about 80 percent of admissions for private and general hospitals across the decade (Figure 16 and Figure 17). However, private hospitals show a large increase from 1970 to 1975, which may have to do with deinstitutionalization. Additionally, people with nonpsychotic disorders made up about 15 percent of total admissions to private and general hospitals across the decade (Figure 16 and Figure 17). People with brain impairment represented around 5 percent of admissions across the decade for both organizational forms (Figure 16 and Figure 17). Unfortunately, there is no data that would demonstrate how the DSM-III affected total admissions to non-federal general hospitals and private psychiatric hospitals.

Figure 16. Number of Total Admissions from 1970 to 1980 in Non-Federal General Hospitals
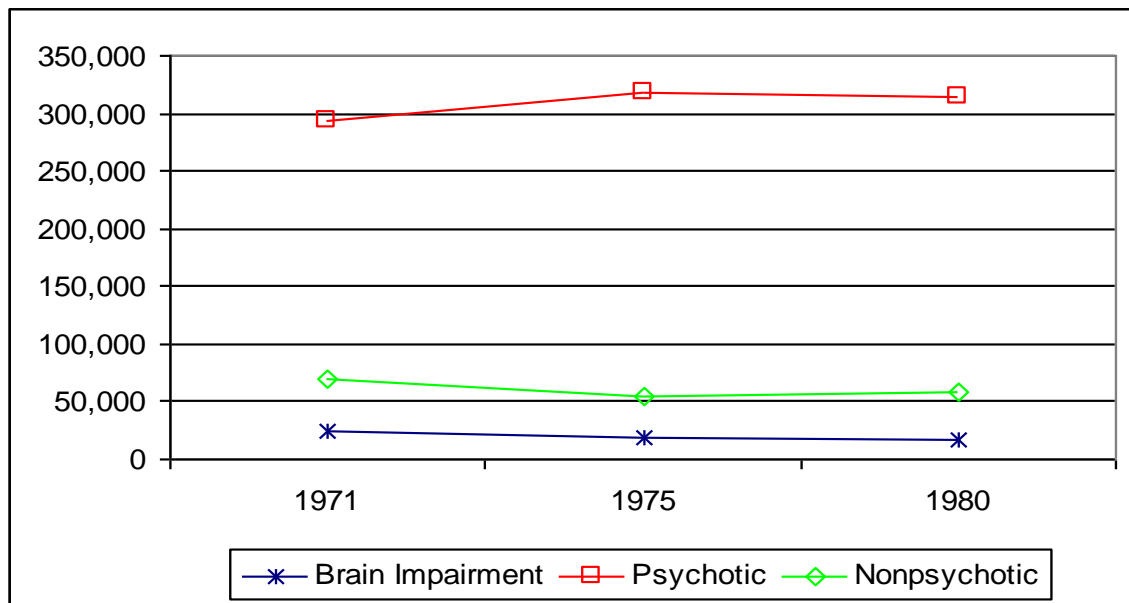
Source: Mental Health 1985

Figure 17. Number of Total Admissions from 1970 to 1980 in Private Psychiatric
Hospitals
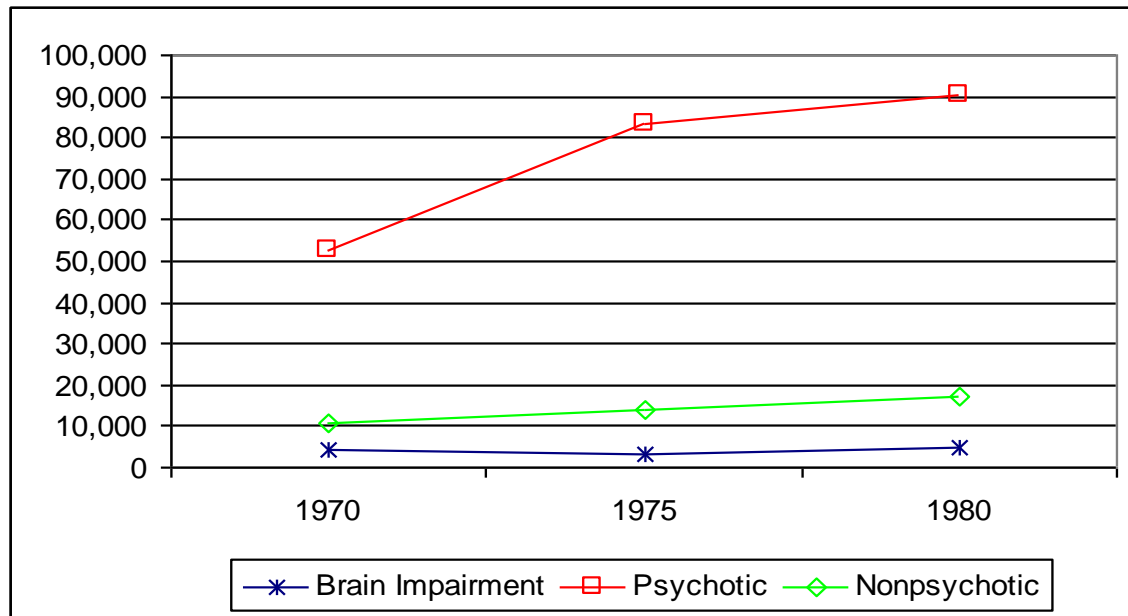
Source: Mental Health 1985

As indicated above, general hospitals became one site of inpatient hospitalization
during this phase of treatment (Kiesler and Simpkins 1993). This is important, because
we would expect similar trends in the patient characteristics, as indicated above (Figure 2
and Figure 15). Using Graves and Lovato.(1981) and *Utilization of Short-Stay Hospitals:*
Annual Summary for the United States, 1979 through 1985, we can see, at least initially,
that the trend of treating nonpsychotic disorders appears to be similar to what occurred
within state and county hospitals during the institutional phase (Figure 18 and Figure 19).

There are; however, some caveats. First, this series of reports presents data on the
use of nonfederal short-stay hospitals based on the National Hospital Discharge Survey.
This data is from a national sample of the hospital records of discharged inpatients, which
can potentially include multiple discharges per person. Second, the diagnoses are not
listed in the same manner, as previous data sources. In *Patients in Mental Institutions*
1947-1965 patients' diagnoses on first admission were broken into various types of

disorders, whereas in the *Utilization of Short-Stay Hospitals* patients' diagnoses,

depending on the year, were broken into categories of disorders. Namely, they were

broken into total number of mental disorders, psychosis, alcohol dependence syndrome,

and neurotic and personality disorders. Psychosis in this survey combined both brain

impairment and psychotic disorders DSM classification numbers 290-299. Subsequently

the nonpsychotic disorders represent DSM classification numbers 300-319. Moreover,

when diagnoses are recorded they are typically recorded using the current DSM, when

reported, hospitals typically use the ICD. Subsequently, variation occurs in translation

from DSM to ICD. This allows for a very loose categorization with some cross

classification problems, such as bipolar disorder with schizophrenia. However the trends

they present are supportive of previous findings, which suggest after the implementation

of the DSM-III the focus on mental disorders seemed to change.

Despite various shortcomings, these data show a similar trend as Figure 2,

"Percent of First Admission to State and County Hospitals", which indicates

nonpsychotic disorders, were the majority of first admissions from the early 1960s

through 1972. This research interpreted this phenomenon as representing the conceptual

shift in psychiatry by adopting the psychosocial model of mental illness and the

subsequent use of the DSM-I and DSM-II. Figure 18 shows a similar process, where

those with nonpsychotic disorders made up the majority of discharges until later in the

1970s and early 1980s. Figure 19 demonstrates the change in the conceptualization of

mental illness, as reflected in patient characteristics, begins to change from 1980 to 1981.

This was a conceptual shift from the psychosocial model to the biological or Kraepelinian

nosology. Psychotic disorders began recapturing the attention of the psychiatric

discipline. One interpretation of this change is that when the nosology began to focus

more on illness conditions and not the behaviors associated with the diagnosis (Horwitz

2002b), emphasis shifted in short-stay hospitals from nonpsychotic disorders to psychotic

disorders. Again, this finding suggests, as the cultural cognitive conception of mental

illness changes, who is identified and treated as mentally ill in this particular

organizational form also changes.

Figure 18. Percent of Patients with a Diagnosed Mental Disorder Discharged from Short-Stay Hospitals by Selected Diagnostic Categories 1974-1978[7]
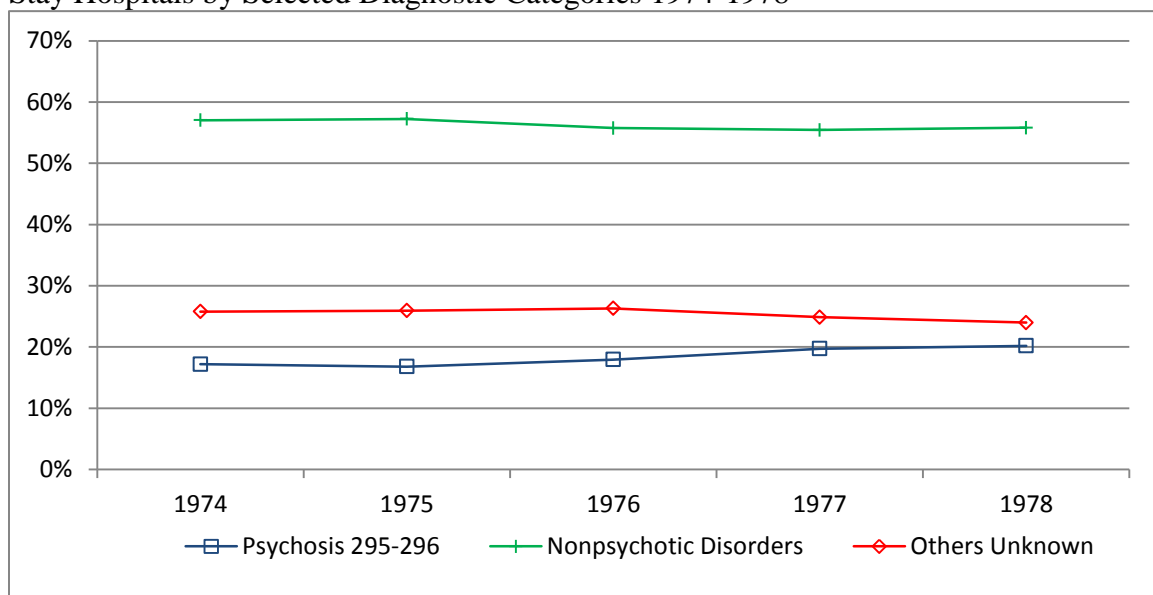
Source: Graves, Edmund and Chris Lovato 1981 "Utilization of Short-Stay Hospitals in the Treatment of Mental Disorders: 1974-1978" *Advance Data Vital and Health Statistics* Number 70 U.S. Department of Health and Human Services, Public health Service, Office of Health Research, Statistics, and Technology.

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[7] Psychosis consists of Schizophrenic and Affective disorders and Nonpsychotic disorders consist of Alcoholism and Neurosis.

Figure 19. Percent of Patients with a Diagnosed Mental Disorder Discharged from Short-Stay Hospitals by Selected Diagnostic Categories 1979-1985
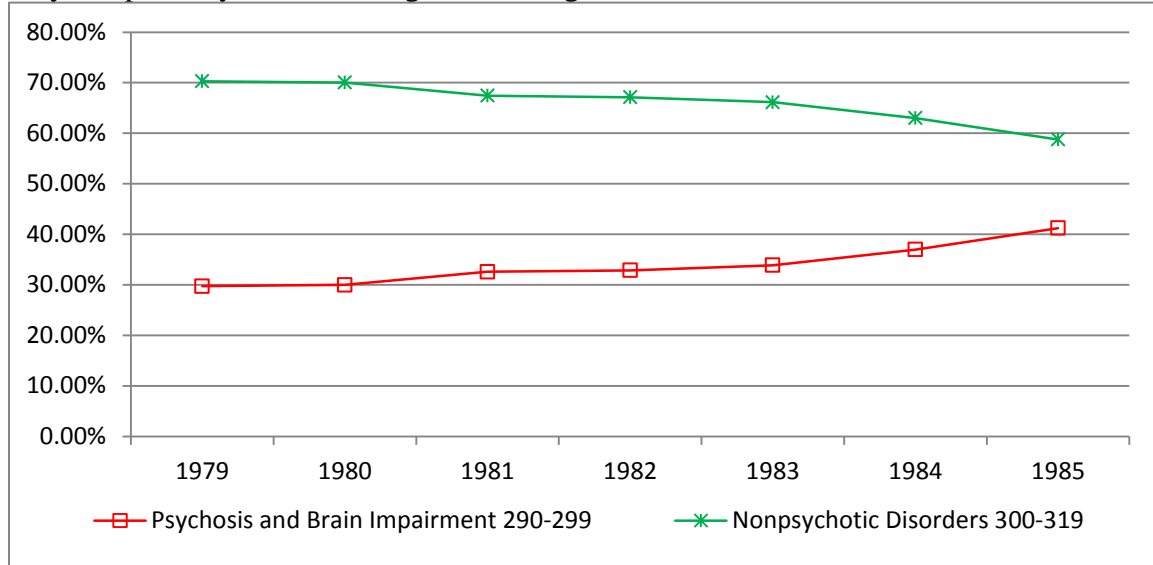
Source: *Utilization of Short-Stay Hospitals: Annual Summary for the United States*, 1979 through 1985

In addition to this finding, that suggests cultural cognitive conception of mental illness change the patient diagnostic characteristics, a number of authors evaluated diagnostic practices pre- DSM-III and post-DSM-III implementation and observed changes in diagnoses over time (Grace and Stiers 1989; Kiesler and Simpkins 1992; Kiesler and Simpkins 1994; and Loranger 1990). First, Grace and Stiers (1989) examined changes in veteran administration diagnosis of Schizophrenia and Affective disorder. Rates of diagnosis for schizophrenia, affective, and all other disorders increased; however, the rate of increase was less dramatic for schizophrenic disorders. This research concluded that tightened criteria for schizophrenic disorders led to fewer diagnoses, which increased the rate of diagnosis for affective disorders. Moreover, the rates of all other disorders increased as well although not as dramatically as affective disorders (Grace and Stiers 1989).

Loranger (1990) evaluated how the DSM-III changed diagnostic practices at a large psychiatric hospital affiliated with a university. This study finds, similar to Grace and Stiers (1989), that there was a large reduction in the diagnosis of schizophrenia and a corresponding increase in affective disorders. However, he also finds a large increase in the diagnosis of personality disorders. Coupled with Grace and Stiers (1989) finding of all other disorders increasing, counters what this chapter suggests—that nonpsychotic disorders were decreasingly important. Finally, Kiesler and Simpkins (1992) evaluated changes in diagnostic case mix in short-term, nonfederal general hospitals using national data. This study found, similar to the previous two studies, a large increase in affective disorders and a decrease in the diagnosis of schizophrenia. Conversely, nonpsychotic disorders decreased, such as adjustment disorder, depressive neurosis, other neurosis, and personality disorders.

After the DSM-III was implemented schizophrenic disorders decreased. Two studies examined national data with multiple treatment organizations (Grace and Stiers 1989 and Kiesler and Simpkins 1992) and supported this general trend of shrinking schizophrenic diagnosis and increasing affective diagnosis, although Kiesler and Simpkins (1992) show rates of schizophrenia increasing on inpatient psychiatric wards of general hospitals. The reason given for the reduced numbers of schizophrenic diagnosis was the restriction of the criteria. For example, those who had exhibited a full affective syndrome before the onset of psychotic symptoms were excluded from the classification of schizophrenia and included in the affective disorder grouping, which increased the number of patients with affective disorders (Grace and Stiers 1989; Kiesler and Simpkins 1992; Loranger 1990).

Kiesler and Simpkins (1992) provide a number of potential reasons for the dramatic increase in psychotic disorders compared to other nonpsychotic disorders. First, they suggest physicians and hospitals attempt to "game the system" (160) by assigning more severe diagnoses to patients, the length of stay and the opportunity for billing would increase. Second, they suggest the implementation of the DSM-III is a reason for the increase in psychotic disorders. Additionally, Kiesler and Simpkins (1992) was the only study that examined nonpsychotic disorders as well as psychotic disorders. They find that nonpsychotic disorders decreased after the implementation of the DSM-III.

Taken together these studies support my assertion that after the implementation of the DSM-III psychotic disorders became more important. However, only Kiesler and Simpkins (1992) findings support my assertion that nonpsychotic disorders decreased in importance as the conceptualization of mental disorders changed

The finding that nonpsychotic disorders decreased contradicts Grace and Stiers (1989) and Loranger (1990) finding that all other and personality disorders increased, respectively. There could be multiple reasons for this discrepancy in these studies. First, Grace and Stiers (1989) looked specifically at schizophrenia and affective disorder and combined all other diagnosis in one category, which may include other disorders whose symptoms produce psychosis. Second, Loranger's (1990) research focused on one hospital, which may or may not mirror national trends. Nevertheless, as a whole these studies suggest that the implementation of the DSM-III had an important influence on the mental patients' treatment career, with all three studies showing an overall increase in psychotic disorder's being admitted for treatment. This is not to say that psychiatry and related disciplines ignored nonpsychotic disorders. However, it is to say nonpsychotic

disorders were increasingly treated in different organizational forms other than inpatient treatment settings.

Another important development during this phase was the introduction of Medicare and Medicaid, which financially supported residential care in nursing homes. Subsequently nursing homes became an important residential care resource for those with mental illness (*Mental Illness in Nursing Homes: United States* 1985). According to *The National Nursing Home Survey* (1973, 1977, and 1985) resident characteristics changed dramatically from 1969 to 1985. Figure 20 distinguishes those patients with a primary diagnosis of brain impairments or mental illness between 1969 and 1973. This distinction shows brain impairment as primary diagnosis was the main reason total mental disorder increased from 1969 to 1973. Moreover, residents with mental disorders as primary diagnoses also increased, however not as noticeably as those with brain impairment. The data from the first of the three waves of *The National Nursing Home Survey* (1973) does not allow for further delineation of mental illness into psychotic and nonpsychotic disorder. Thus, it is unclear whether the majority of primary diagnosed residents suffered from psychotic or nonpsychotic disorders.

Figure 20. Number of Nursing Home Residents by Primary Diagnosis at Last Medical Examination and at First Admission, 1969 and 1973
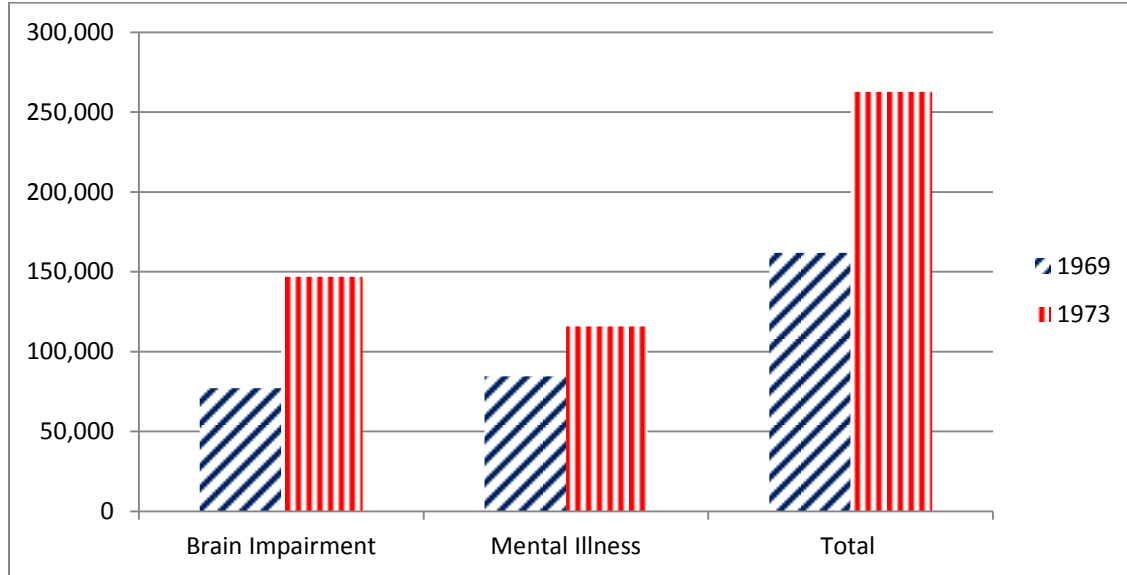
Source: The National Nursing Home Survey 1973

However, using *The National Nursing Home Survey* 1977 and 1985, Figure 21 allows more precise delineation of categories. First, those diagnosed with some type of brain impairment increased meagerly, by about 5,000 over the eight year period. Both psychotic and nonpsychotic disorders increased, with psychotic disorders increasing by almost 30 percent and nonpsychotic disorders increasing 37 percent over the eight years. Although primary diagnosis at either the last examination or at admission does not provide us with information with every patient in nursing homes with a mental disorder, it does allow us to see trends. These trends suggest even though brain impairment increased, both psychotic and nonpsychotic disorders as a primary diagnosis for nursing home residents were increasing throughout this phase of treatment. However, they did not surpass brain impairment as the most frequent diagnosis in nursing homes.

Figure 21. Number of Nursing Home Residents by Primary Diagnosis at Last Medical Examination and at First Admission, 1977 and 1985
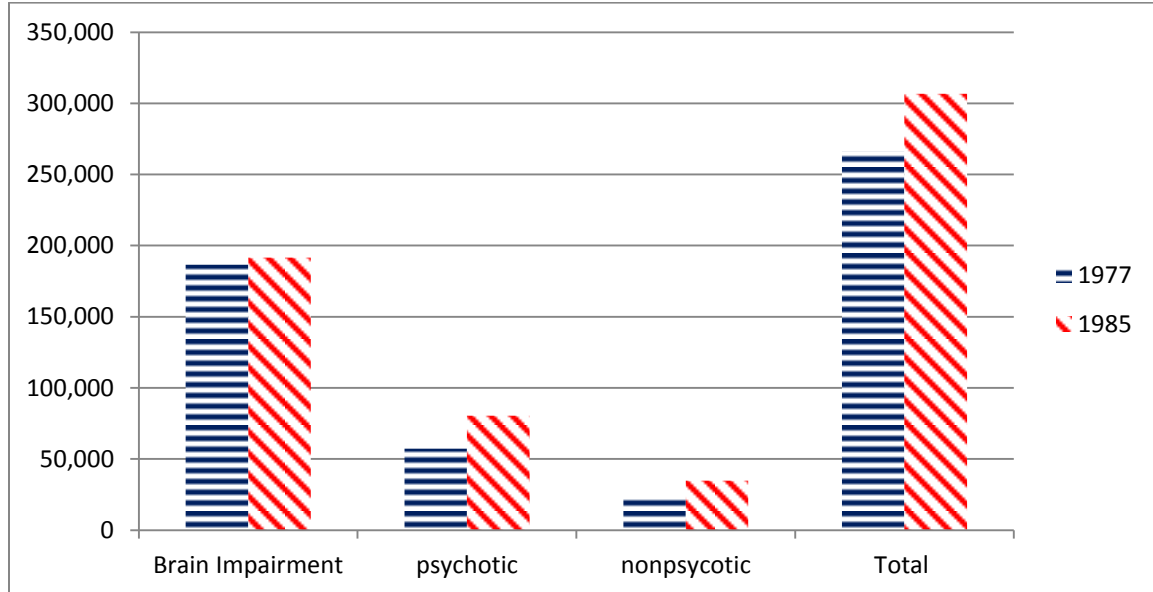
Source: The National Nursing Home Survey 1977, and 1985

Finally the *Mental Illness in Nursing Homes: United States,* (1985) allow for an examination of nursing home residents by chronic conditions. Chronic conditions were reported as including long-term physical and mental problems of nursing home residents, which were selected by the staff respondent. In this research I will focus on those illnesses that are mental problems. This selection was generated from a list of 37 problems and was based on the respondents' knowledge of the resident and the residents' medical record (Kramer 1986). Moreover, "the respondent based the selection upon a check of the medical record and more than one condition or impairment could be reported" (*The National Nursing Home Survey* 1977: 141).

Based on the data, over 80 percent of nursing home residents had some type of brain impairment, 22 percent had some type of psychotic mental disorder, and 40 percent had some type of nonpsychotic disorder (Figure 22). Figure 21 indicates nonpsychotic disorders as a primary diagnosis are rare, even when taking into account the increased

prevalence in the diagnoses between 1977 and 1985. However, when compared to Figure 22 almost 40 percent of the nursing home population has some type of nonpsychotic disorder.

The large number of nonpsychotic disorders could be a consequence of organizational context. For example, because nursing home residents tend to reside for a long time they could acquire additional nonpsychotic disorders such as depression and/or anxiety. Moreover, the numbers for brain impairment and psychotic disorders also indicate that residents of nursing homes suffer from multiple problems which are compounded by the chronic condition of mental disorder.

Figure 22. Number of Nursing Home Residents by Type of Chronic Mental Disorders 1985[8]
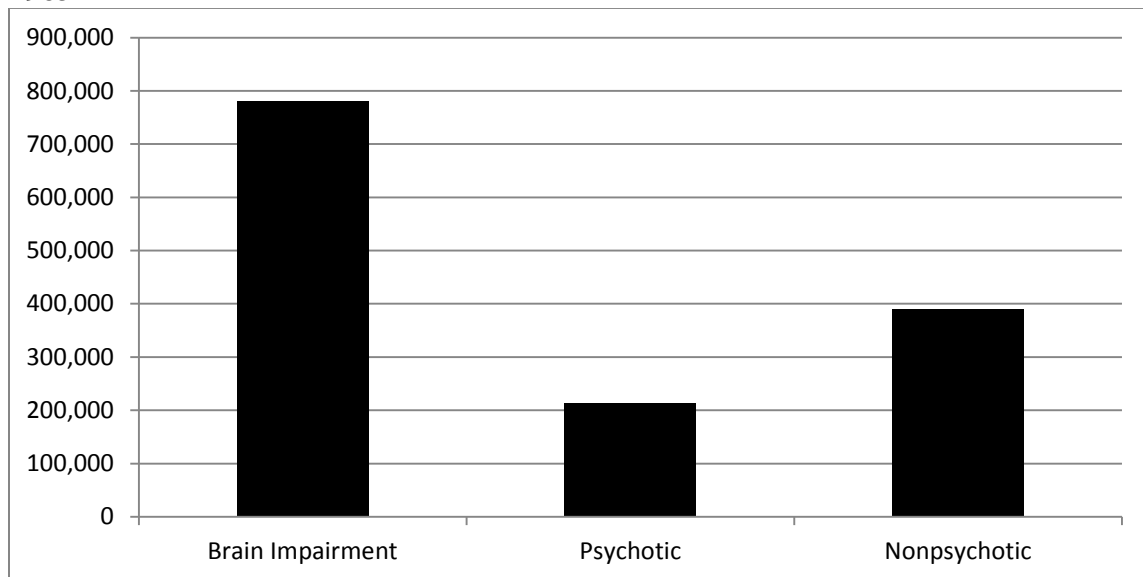
Source: Mental Illness in Nursing Homes: United States, 1985

There appear to be two separate events occurring in nursing homes from 1969 to 1985. First, between 1969 and 1973 (Figure 20) we can see the rapid increase in nursing home residents with brain impairment. This increase in residents would presumably have

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[8] Values in Figure U will equal more than the number of patients because some residents had more than one type of chronic disorder.

come from what is referred to as transinstitutionalization where patients from state and county mental hospitals were transferred to the nursing homes. Next, between 1977 and 1985 (Figure 21) we see an increase, although not as dramatic as the first, of psychotic and nonpsychotic disorders as primary diagnoses in nursing homes. This, increase in psychotic and nonpsychotic disorders may have been driven by the introduction of the DSM-III and the subsequent reconceptualization of mental disorders and the overall increase in disorders.

In addition, when examining the primary (Figure 21) and chronic (Figure 22) diagnoses for 1985, we can begin to see the prevalence of all three different categories for mental disorders, which leads to some tentative conclusions. First, the nursing home's role in the treatment of mental illness was to provide a residential facility for old people, whose primary diagnosis was typically a severe condition such as brain impairment and/or psychosis. Next, all three categories increased dramatically when incorporating all chronic conditions instead of looking exclusively at the residents' primary diagnosis, which suggests these different types of disorders tend to co-occur with other medical problems. Finally, nonpsychotic disorders played a small role in primary diagnosis. However, because of its dramatic increase when examining chronic conditions, we can understand that these disorders would presumably be caused by environmental factors, which include but are not limited to the nursing home itself.

Although a substantial number of nonpsychotic disorders were treated in general hospitals and state and county hospitals, nonpsychotic disorders in general hospitals and state and county hospitals became a decreasingly important diagnosis over the 1980s (Figure 15 and Figure 19). Moreover, even though a large number of nursing home

patients suffered from nonpsychotic disorders as a chronic condition (Figure 22), few

residents carried this disorder as primary diagnoses (Figure 21). These findings suggest

nonpsychotic disorders were no longer the primary reason for receiving treatment;

however, as indicated above, psychiatry and its related disciplines did not ignore these

disorders. It is true that nonpsychotic disorders were no longer the central focus of

inpatient treatment; however, they became increasingly important in outpatient treatment.

For example, Figure 23 indicates a large number; over 70 percent of 2,316,754 disorders

being treated in outpatient organizations were nonpsychotic. While this graph only

captures one year during the beginning of the community-based care phase, it gives us an

indication that nonpsychotic disorders were primarily treated in outpatient psychiatric

centers.

Figure 23. Outpatient Psychiatric Services Percent Care Episodes by Diagnosis 1971
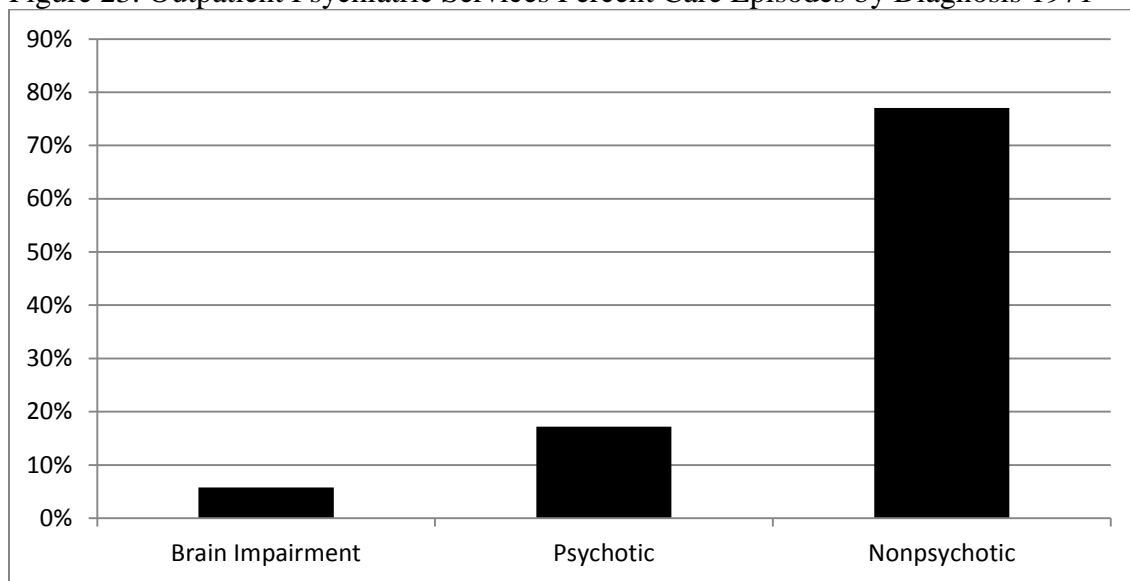
Source. Redick, (1973) Statistical Note 92, National Institute of Mental Health

Unfortunately, what happened from 1972 to 1985 during this phase and whether

the treatment pattern for brain impairment, psychotic, and nonpsychotic disorders

changed is unknown for outpatient psychiatric services. However, Figure 23 indicates

outpatient psychiatric services were designed for and treated primarily nonpsychotic

disorders. Figure 24, developed with *The National Ambulatory Medical Care Survey*

(1979) supports the idea that nonpsychotic disorders were dealt with outside of inpatient

organizations. However, this survey did not provide information about outpatient

psychiatric services and does not allow us to clearly delineate between brain impairment,

psychotic, and nonpsychotic disorders. This survey it does show, out of 24,580 office

visits by diagnosis two types of nonpsychotic disorders account for over 50 percent of

office visits, neurotic and personality disorders. Schizophrenic disorders a psychotic type,

only accounted for seven percent of office visits.

Figure 24. Number of Ambulatory Office Visits by Principal Diagnosis
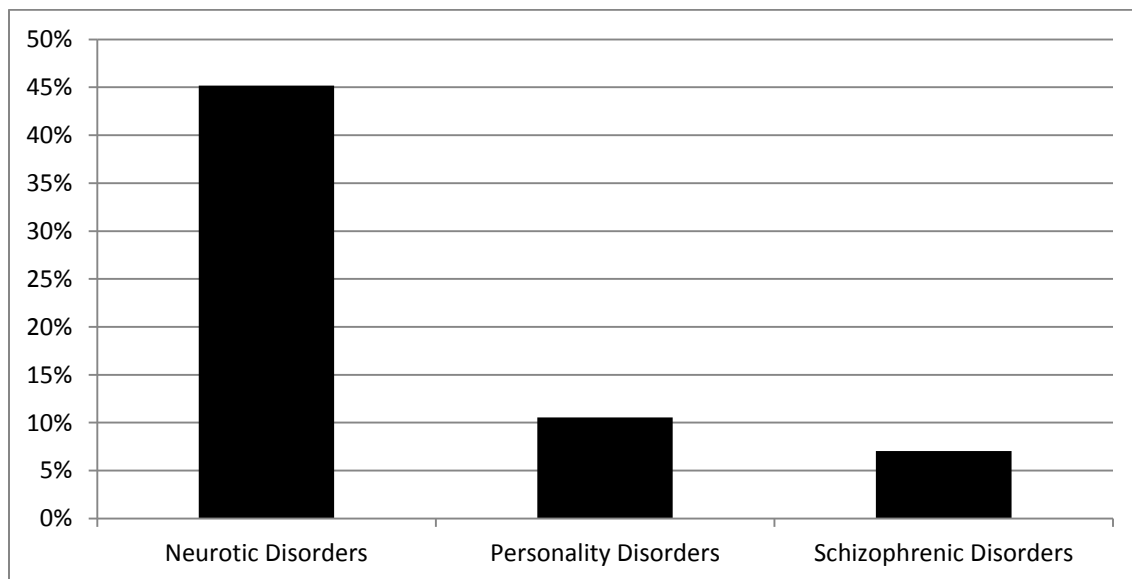
Source: The National Ambulatory Medical Care Survey 1979

As the data show state and county mental hospitals lost their dominate role in the

institutional structure used treated mental illness. The two organizational forms that took

over inpatient treatment from state and county mental hospitals were general hospitals

and nursing homes. These two organizational forms were primarily responsible for

treating two distinct types of patients with different disorders. General hospitals

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predominantly treated those going through an acute crisis, whereas nursing homes tended to treated those with brain impairment a chronic impairment. During the 1970s and early 1980s general hospitals tended to treat more nonpsychotic disorders. However, this began to change after the publication of the DSM-III and they began treating more psychotic disorders than nonpsychotic disorders. Nursing homes, on the other hand, primarily treated residents with brain impairments. Outpatient treatment was another organization that replaced state and county mental hospitals. This element of the mental health care sector was structured to treat a specific category of disorders, nonpsychotic. However, because of a lack of data it is not clear whether this is the case over the entire phase.

In addition to the structural changes that occurred during this phase, all three inpatient organizations (state and county mental hospitals, general hospitals, and nursing homes) were affected by the implementation of the DSM-III and the types of disorders being admitted. For example, in general hospitals psychotic disorders increased. In nursing homes both psychotic and nonpsychotic diagnoses increased after the introduction of the new DSM-III, although they were not as prominent as brain impairment disorders. This is not to suggest that because of the introduction of a new diagnostic manual that practitioners began haphazardly assigning disorders. However, it does suggest that with the re-introduction of the Kraepelinian nosology, symptoms began to represent distinct disorders, which increased the number of diagnoses and patients.

Treatment Patterns and Theories

Just as in the institutional phase, the two broad categories of treatment methods for mental illness were physical and psychological therapies (Horwitz 2002b). Both forms of therapy were practiced. However, because of the institutional context they took

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on different forms than in the institutional phase. The physical forms in this phase were mainly psychotropic medications, although, electroshock therapy was used for specific types of disorders, which were resistant to drug therapy (O'Mahony and Travis 1998). The psychological therapies used had largely changed from psychoanalytic to cognitive/behavioral and humanistic types of therapies (U.S. Department of Health and Human Services 1999). During this time, psychoanalytic orientation towards mental illness began to wane and consequently the practice of psychoanalysis declined, although psychoanalytic therapies were still used (Engel 2008).

The discipline of psychiatry once directed by the psychosocial or psychoanalytic model and invested in psychoanalysis, now started to focus on biological and neurological orientation. Because psychoanalysis was viewed as ineffectual, growing competition from nonmedical therapists, and declining reimbursement from insurance plans, the professions of mental health care changed its treatment. Moreover, after 1970 psychiatry lost its therapeutic hegemony and began to stop providing nonmedical therapy. Psychiatry was forced to shift its focus towards the biological and medical practices of mental health treatment (Engel 2008). This biological ascendancy culminated in the 1980s and was symbolized with the removal of almost all discussion of neurosis from the DSM-III (Engel 2008).

However, biological psychiatry had its roots in the development of psychotropic medications that were introduced in the 1950s (Bond and Lader 1996; Engel 2008). According to Engel (2008) these drugs not only changed how psychiatrists treated mental illness they also changed how they conceptualized mental illness. These new psychotropic medications reduced schizophrenic hallucinations and delusions whereas no

other type of treatment worked as well. Increases in prescription drugs to treat mental disorders increased substantially during the 1960s and 1970s. "From 1961 until 1972, there was an increase of 100 percent or more in manufactures' sales of most major categories of drugs, including the three largest types, i.e., central nervous system drugs, anti-infectives, and the category witch included contraceptives…Valium, introduced in 1963, became the most frequently prescribed drug in the United States by 1972" (Kenig 1992: 77). Moreover, by the 1970s, studies showed psychotropic medication produced positive effects on depression, bipolar disorder, and anxiety disorders. Depression and anxiety, though, worked better with a combination of psychotropic drugs and nonmedical therapy (Engel 2008). Subsequently, treatment was provided in short-term inpatient facilities, with an emphasis on medications and proper functioning within the community (Kemp 2007).

Psychiatry now worked with other professionals to provide a multipronged approach toward treatment (Engel 2008; Lucey 1998). Typically, what is recommended was the use of psychotropics in combination with psychological treatments and consideration of the patients' social environment (Lucey 1998). The two main disciplines that began to takeover nonmedical therapeutic practices were clinical psychology and clinical social work. Between the 1960s and 1980s, both disciplines increased in numbers, while the number of psychiatrists declined. Both professions were reimbursed from private insurance plans; however, both professions were dependent on psychiatrists to practice. For example, clinical psychologists trained under psychiatrists and in some states depended on them for prescription privileges. Social workers were confronted with similar, if not more, problems. They too were dependent on psychiatry for admitting and

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prescription privileges and had lower prestige levels compared to psychiatry (Engel 2008).

In addition to professional changes in providing the nonmedical therapy, the therapy itself changed from psychoanalysis to cognitive/behavioral (Engel 2008; O'Dwyer 1998) and humanistic therapies (U.S. Department of Health and Human Services 1999). This was a consequence of numerous studies conducted during the late 1960s and the decade of the 1970s, which asserted that psychoanalysis did not work when treating mental illness. Moreover research provided evidence that suggested the amount of time spent in therapy by psychoanalysis was excessive, which helped impart therapeutic changes. Best results in therapy were generated in the first twelve sessions and if the sessions went longer, few patients showed progress after the twelfth session but after twenty sessions, the patient's initial problems could worsen (Engel 2008). Together cognitive and behavioral therapies were shown to have effective outcomes for certain diagnoses, such as obsessions, compulsions, phobias, some personality disorders, unipolar depression, and anxiety (Engel 2008; O'Dwyer 1998).

Because of coercive (i.e., demands from insurance companies) and normative (i.e., pressure from competing disciplines and the use of psychotropic medication) isomorphic forces, psychiatry shifted from the psychosocial model to the biological and medical practices in mental health treatment. Another change, during this phase, was treatments were specifically designed and used to treat explicit disorders with discrete symptoms, which fell in line with the Kraepelinian nosology (Horwitz 2002b). Consequently the cure-all ethos that treatment's previously carried disappeared and you

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began to see the development of specific treatments for specific mental disorders (Bond and Lader 1996).

Where Treatment Occurs

As indicated in the last chapter there was an increase in variance of organizational forms as the structure of treatment began to change from predominant use of inpatient treatment to the principal use of outpatient treatment. This change was the result of shifts in the cultural-cognitive, normative, and regulative elements of the institution of mental health care. The Joint Commission on Mental Illness and Health (1961) provided a cultural-cognitive template to guide the institutional transition of the locus of care for people with mental disorders. This framework led to coercive forces in the form of federal and state legislation requiring community-based programs, psychiatric units in general hospitals, and community mental health centers. Moreover, this legislation had developed procedures to reduce the length of stay and prevent inappropriate placement for patients in state and county mental hospitals. Finally, the expansion of nursing homes and other organizations designed for old people, originated from amendments to the Social Security Act in 1965, which established Medicare and Medicaid (Kramer 1986).

Geller (2000) argues by the mid-1960s there was an understanding of what community-based treatment meant. It denoted an assemblage of support and treatment procedures that met the needs of patients, when they needed them, during the patients' life-course. This enforced the earlier established principles of community treatment: patients should remain in the community and hospitalization, if required, should be short (Geller 2000). Figure 25 shows the transition from the use of inpatient care in the mid 1950s to increased use of outpatient care in the late 1960s and early 1970s. What changed

was the dramatic increase in the use of outpatient care episodes in the early 1970s. This exemplifies the creation and institutionalization of a new orientation towards treatment, the community-based model of care (Figure 25).

Figure 25. Number of Patient Care Episodes by Type of Service 1955 to 1986
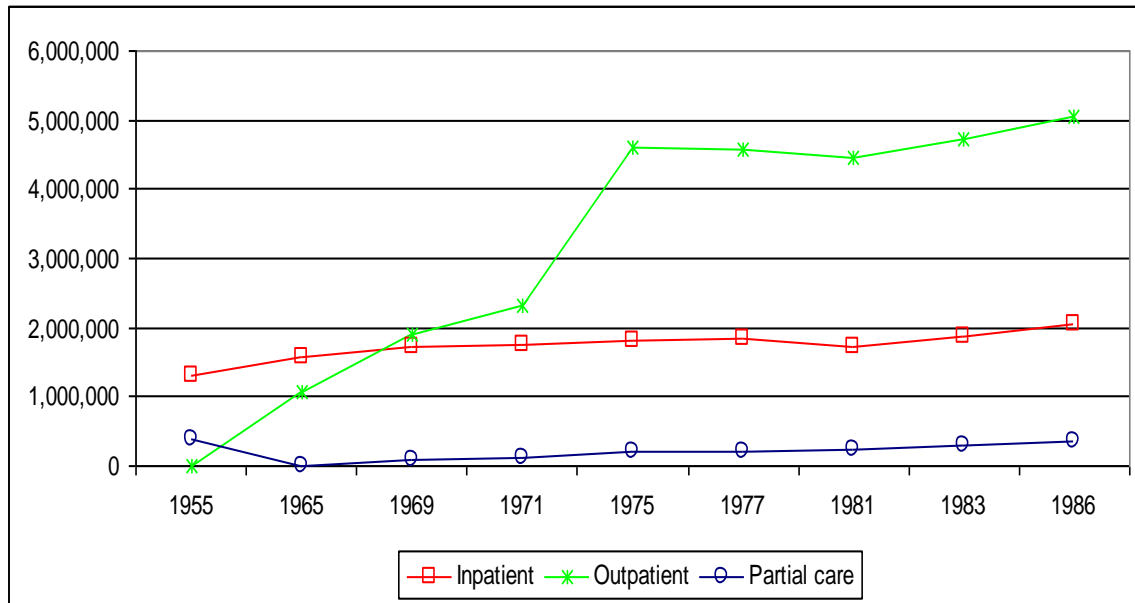
Source Mental health Statistical Note no. 192 *Patient Care Episodes in mental health Organizations, United States: Selected Years between 1955 and 1986*

As outpatient services increased, numerous organizations provided these services as indicate by Figure 26. An outpatient mental health clinic is defined as "an organization that provides only ambulatory [nonresidential] mental health services. The medical responsibility for all patients/clients and/or direction of mental health program is generally assumed by a psychiatrist" (Mental Health, United States, 1985: 157). The Community Mental Health Centers (CMHCs) were an important element in outpatient organizations that were supposed to prevent or ameliorate mental illness through community oriented preventative, diagnostic, treatment, and rehabilitation services. Moreover, it was supposed to replace the state mental hospitals as the center of treatment

(Grob and Goldman, 2006). As discussed previously, the CMHCs had a difficult time accomplishing their task.

As Figure 26 shows, independent psychiatric outpatient clinics and federally funded CMHCs were prominent organizational forms handling a majority of the patients, until the early 1980s. Then with the disappearance of the federally funded CMHCs, because of policy changes made in the Regan administration, independent psychiatric outpatient clinics increased their numbers substantially. These outpatient organizations were responsible for a large portion of treatment. In fact, in 1955 state and county mental hospitals made up 49 percent of all patient care episodes (1.7 million) in mental health facilities; however, by 1975 outpatient psychiatric services made up 47 percent of all patient care episodes (6.4 million) in mental health facilities (Taube and Redick 1975). These numbers show the changing roles for two organizational forms as well as how mental health care expanded dramatically during this time.

Figure 26. Number of Outpatient Additions by Select Type of Organization
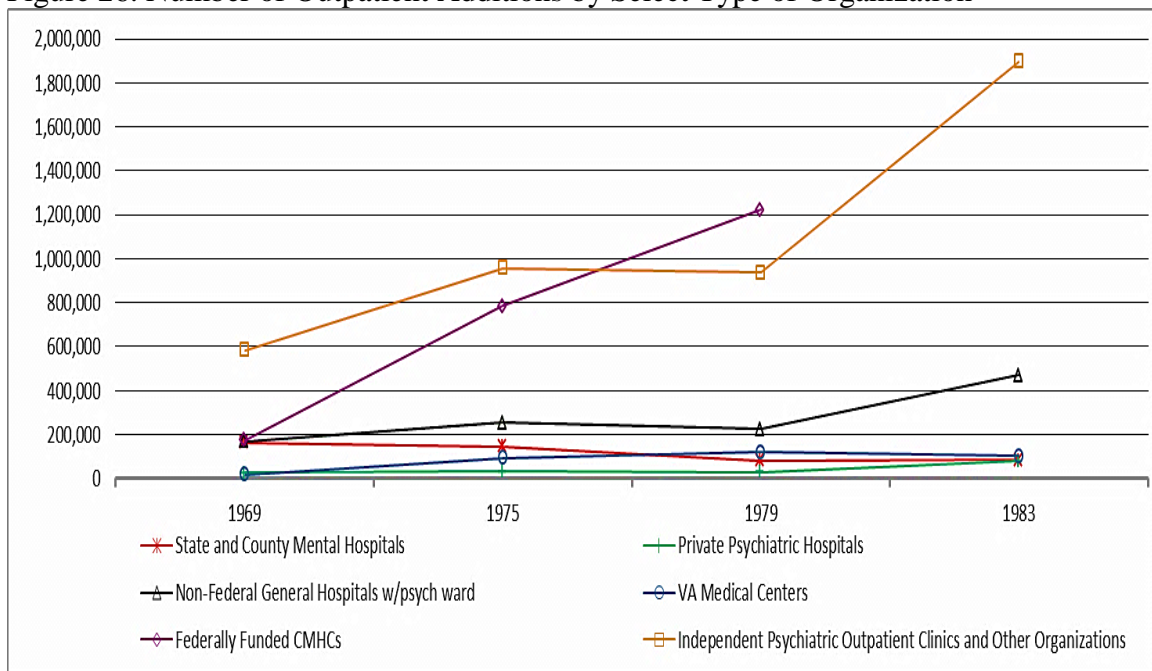
Source. Mental Health, United States 1992

Despite the previous findings, it is important to note the data suggest outpatient care did not replace inpatient care, because inpatient care episodes remains relatively stable for the 30 years measured. Despite this stability, this does not mean that nature of inpatient care did not also change. Figure 27 illustrates the turbulence within the inpatient care setting, where the majority of inpatient care episodes occurred in the state and county mental hospital until the mid to late 1970s. As we can see from Figure 27, inpatient care episodes changed from predominately occurring in state and county mental hospitals to the psychiatric wards of general hospitals. It is however, important to note inpatient care did not decrease during the process known as deinstitutionalization, even though patients' care episodes were less likely to occur at state and county hospitals and length of stay decreased. Organizational roles did change, no longer was the state and county mental hospital the first choice for treatment. This transinstitutionalization and was a major aspect of the process known as deinstitutionalization (Mechanic 2008) and demonstrates the turbulence within the organizational field.

Figure 27. Number of Inpatient Care Episodes by Type of Organization 1955 to 1986
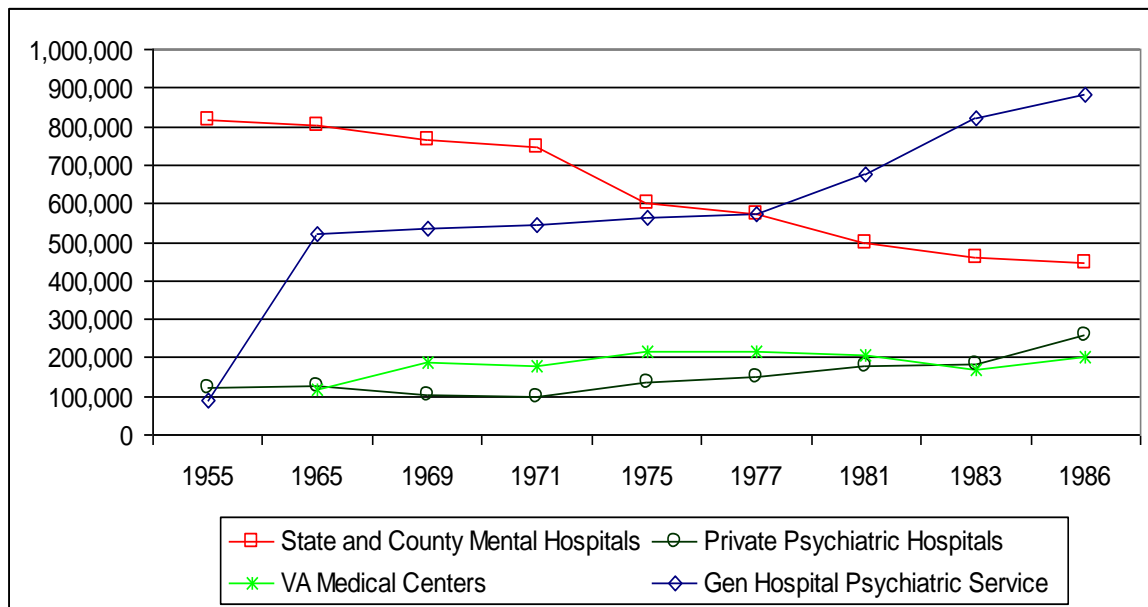
Source Mental health Statistical Note no. 192 *Patient Care Episodes in mental health Organizations, United States: Selected Years between 1955 and 1986*

Paralleling the decline in residents in state and county hospitals as shown in Figure 14 and the decreasing number of inpatient care episodes in state and county mental hospitals (Figure 27), Figure 28 shows the decline in yearly total admissions in state and county hospitals beginning in early 1970s. Moreover, during the 1970s psychiatric wards in general hospitals surpassed state and county mental hospitals in their patient admissions. Private psychiatric hospitals also increased their admissions during the 1970s. Moreover, it is important to note (Figure 14) as residents decreased total yearly admissions increased (Figure 28). This is important because it signifies a change in the nature of treatment for the mentally ill. For example, the idea that an individual experiencing mental illness could be removed from society, in the name of treatment, for extended periods of time became increasingly less likely, regardless of the individuals' circumstances and the severity of the disorder. Similar to Geller (2000) argument about the majority of the decrease in patient population of state and county hospitals happening

because the length of stay decreased; the general hospitals also decreased the length of

stay. Thus, the institutional logics required shorter stays and the new organizational forms

were designed and operated with that logic in mind.

Figure 28. Total Yearly Admission to Mental Hospitals by Type of Organization
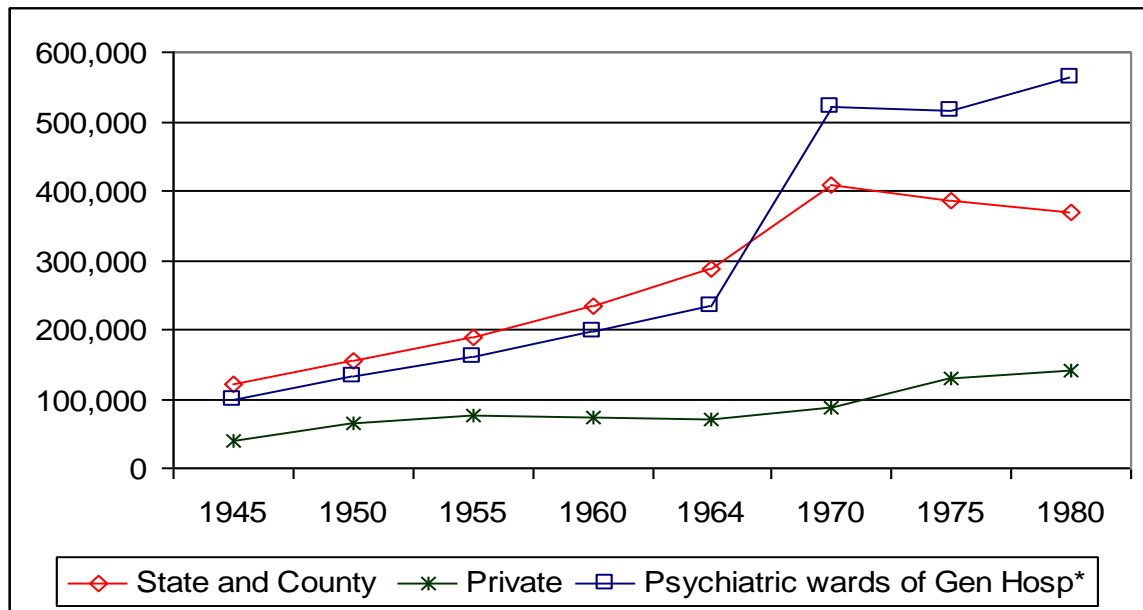
Source *Patients in Mental Institutions* 1947-1965 and *Mental Health, United States* 1985
from the National Institute of Mental Health[3]

Figure 14, Figure 27, and Figure 28 depict the beginning of the end for state and

county mental hospitals and their declining importance for treating those with mental

illness. This has had substantial implications for people with mental illness and their

treatment career. Not only did the prevailing type of service change from inpatient to

outpatient, but the type of hospital used to treat the majority of inpatient cases changed

too. Additionally, the fact that both outpatient services and psychiatric wards of general

hospitals became more and more important during the community-based care phase

supports the idea that the community-based model of care was institutionalized during

this phase. Outpatient services provide emergency services, extend treatment into

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[3] Admissions values represented under Psychiatric wards of General Hospital 1970 were for 1971

community settings, and broaden the conceptions of care, including pharmacologic and psychotherapy, with varying degrees of intensity (Joint Commission on Mental Illness and Health 1961). Psychiatric wards of general hospitals were used to keep hospital stays shorter than what had previously been considered normal (Dowdall 1999). Together outpatient services and psychiatric wards of general hospitals are important structural component for the community-based model of care, which enables more care to occur in the community and not in long-term hospitals.

Nursing homes and correctional facilities began to play a larger role in patients' mental illness career during this phase. The first organizational form was the nursing home. Nursing homes were not a new organizational form and their role has changed over time. For profit nursing homes went through three significant changes from the 1930s to the 1960s. The first was the Social Security Act (1935) where people who could not afford, were provided funds, allowing them to pay for private lodging in boarding homes. By the 1950s, as their residents became increasingly disabled, nursing services were added. Then in 1965 Medicare and especially Medicaid enabled residents to receive federal funds for inpatient residential treatment. This enabled the nursing home to be an important player in the transition from the institutional to the community-based care phase (Liptzin 1986). Figure 29 indicates total residents with mental disorders as primary diagnosis at either the last examination or at admission approximately doubled over the 16 year period. Primary diagnosis was the condition reported by the staff respondent as the major diagnosis in the medical record at admission or last examination.

Figure 29. Total Nursing Home residents with Mental Disorder as Primary Diagnosis at Last Examination or Admission 1969-1985
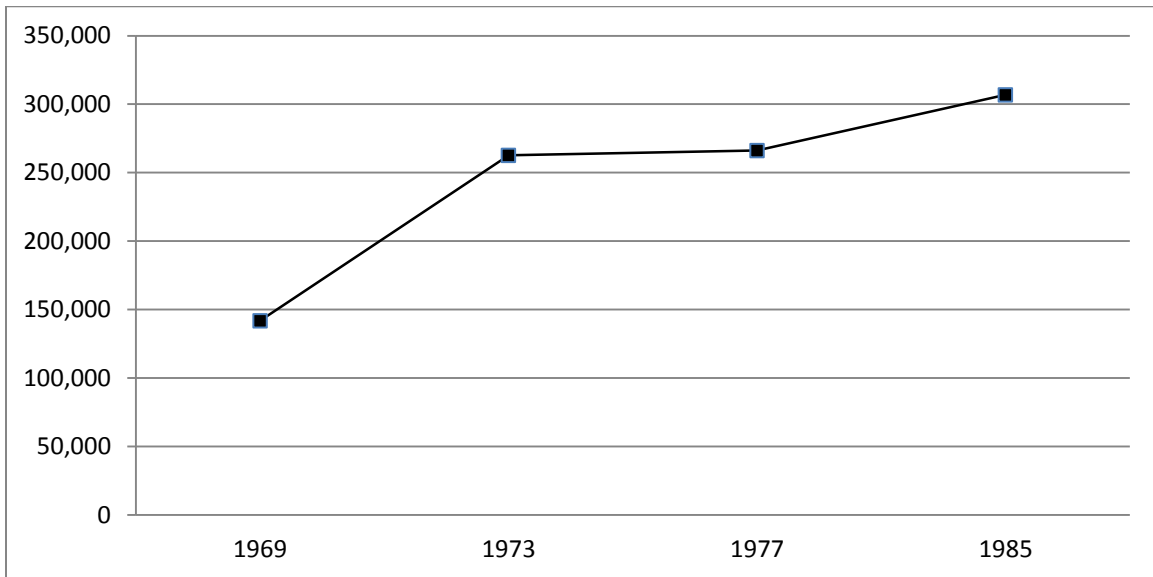
Source: The National Nursing Home Survey 1973, 1977, and 1985.

Subsequently, the nursing homes role began to transition and it was used to treat mental illness in old people during the community-based care phase. This removed a large population away from the state and county mental hospital but also the community. Initially one of the biggest shifts was patients from the state hospitals to nursing homes (Mechanic 2008). There are no precise accounts that show how many of the discharged patients went into nursing homes; however there are indications that the numbers are large. First, in a study conducted by National Institute of Mental Health (NIMH), of the state and county patients who were 65 years or older, forty percent went to nursing homes (Liptzin 1986). Figure 30, shows, from 1973 until 1985, there were 70 to 80 thousand patients, per year measured, living in state mental institutions prior to being transferred into a nursing homes. This does not; however, show the change in the role of the organizations. For example, instead of people being taken to the state or county mental hospitals and then being transferred to a nursing home, people could go from the

community into the nursing home or from the general hospital into the nursing home. Thus state and county mental hospitals became more restrictive in admissions, especially for old people with mental disorders, who instead went into nursing homes.

Figure 30. Outside Living Arrangement Prior to Nursing Home 1973-1985
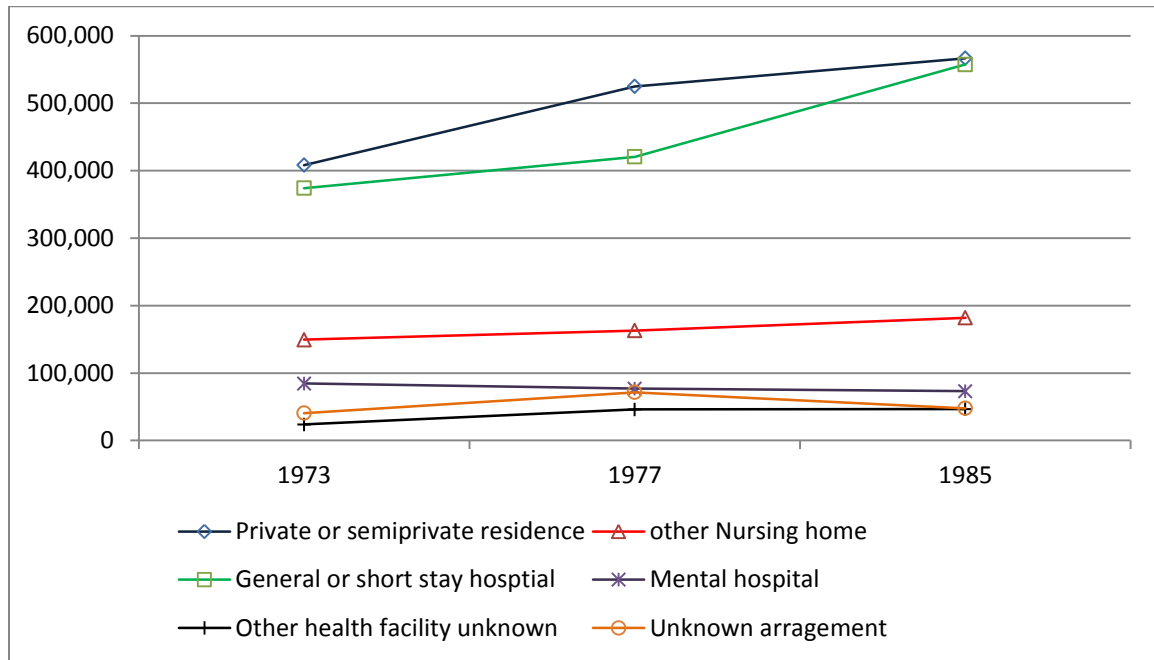
Source. The National Nursing Home Survey 1973, 1977, and 1985

As the numbers indicate in Figure 20, Figure 21, and Figure 22 a large number of residents have some type of mental disorder. During the community-based care phase the nursing home became the principal institution, which provides mental health treatment to old people with mental illness (Bartels and Citters 2005). Burns and Taube (1990) suggest 73 percent of nursing home residents suffered some type of mental disorder. Additionally, in 1980 the overall rate of mental disorder in older American who were institutionalized is around 65 percent and the majority of this 65 percent, were treated in nursing homes, which cared for 94 percent of patients' with mental disorder (Burns and Taube 1990). There is no doubt from Burns and Taube (1990) as well as Figure 19, Figure 20, and Figure 21 that a large portion of mental illness was experienced by nursing

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home residents and this organizational form was tasked, whether consciously or unconsciously, with providing mental health services to a large population.

The second organizational form that became significant during the establishment and implementation of the institutional model centering on the community, was the large number of persons with mental disorders that were absorbed by the criminal justice system (Lamb and Weinberger 1998). Penrose (1939) developed a theory, from data from eighteen countries in Europe, which argued industrial societies have a relatively stable number of persons in some kind of detention. He argues there is an inverse relationship between prison populations and asylum populations and if one type of incarceration is larger, the other will decline (i.e., balloon theory) (Lamb and Weinberger 1998). Although there may be debate as to how much of the correlation is attributed to closing state mental hospitals, the transition from the institutional to the community-based care phase shows striking similarities supporting Penrose's hypothesized institutional population.

In a series of reports sent to congress the U.S. Governmental Accounting Office (GAO) examined the efficacy of prisons (1979) and jails (1980) provision of mental health care. These reports suggest a significant number of inmates, entering prison, had mental health problems. In federal prisons in the late 1970s it was estimated that two percent of inmates were psychotic; however, in two independent state prisons they estimated those with psychotic symptoms comprised between 7 to 14 percent of the inmate population. Moreover, in federal prisons there were an estimated 50 percent of inmates having mental disorders affecting their behavior. For example, inmates with behavioral disorder had diagnoses such as: neurotics, kleptomaniacs, sexual deviants,

psychological arsonists, and those with phobias and aggressive explosive personalities. Finally, in federal prisons there was an estimated 40 percent with drug or alcohol problems; however, in one state prison this number increased to 60 percent of the inmates (GAO 1979). Moreover, the GAO (1980) suggests inmates with mental illness are anywhere between 20 to 60 percent of the nations jailed population.

By the 1970s there were increases, because of mental disorder, in both the incarcerated prisoners and those found incompetent to stand trial. This trend continued into the 1980s where studies in different states indicated people discharged from mental hospitals were showing up in jails and prisons; moreover, there were indications the problems were getting worse (Torrey et al. 2010). Reviewing the literature from the 1970s to the 1990s Lamb and Weinberger (1998) suggest studies show jails had between 6 to 15 percent and prisons had anywhere between 10 to 15 percent of inmates with some type of mental illness.

Although it is difficult to derive the specific rates and types of mental illness from these studies, during the early 1980s a series of jail studies suggest between 5 and 6 percent of the population consisted of serious mental illness, such as schizophrenia, bipolar and major depression disorders (Torrey et al. 2010). Additionally, the GAO (1979) gives us evidence suggesting federal prisons and a few state prisons held between 2 to 14 percent of prisoners with serious mental illness (i.e., having psychotic symptoms). However, these studies were geared toward a basic understanding of the problem and detailed characteristics of the inmate populations were not recorded, making it difficult to know the exact composition of inmate populations.

This section documents the structural changes that occurred during the community-based care phase and the subsequent consequences. The variance in the mental health sector increased as the organizational forms used to treat patients with mental disorder increased. First the role of inpatient care was surpassed by outpatient care. Thus the state and county hospital no longer treated the majority of cases in the inpatient or the outpatient setting. There was also a large portion of old people with mental illness who remained institutionalized; however, in the nursing home instead of state and county hospitals. The data indicate two large increases in mental illness in the nursing home population, first from 1969 until 1973, which is attributed to transinstitutionalization and second form 1977 until 1985 which is attributed to the implementation of the DSM-III. Finally, the role prisons and jails took in the mental patients treatment career, although custodial and not necessarily treatment was important. This was not part of the logic purported by the Joint Commission on Mental Illness and Health (JCMIH) Action for Mental Health report published in 1961. This report and its guiding logics neglected to take into account the severity of illness suffered by a portion of the population being served by state and county mental hospitals. Moreover, it neglected considering if there was any value that state and county mental hospitals had in the day to day functions of some of their resident population.

Threshold for Treatment

During the community-based care phase, the treatment career and how that career was initiated changed. Similar to the previous chapter, the focus of this section is to examine the legal criterion for commitment and then discuss commitment proceedings.

The legal and administrative decisions, which guided the initiation of treatment,

demonstrate the structures used to initiate treatment and their underlying assumptions.

Legal Criterion for Commitment

By the 1960s, questions about psychiatry and its legitimacy began to come to the

fore. The power psychiatrists' held, with few if any oversights, to dispossess people of

their liberty was unsettling. There was increasing doubt about the reality of mental illness

and even if there was no doubt about the reality of mental illness, questions were raised

about the customary treatments for those who suffered (Appelbaum 1994). Moreover,

there is little question that psychiatrists were increasingly using their authority to make

knowledge claims without relying on a body of knowledge to justify their conclusions

(Kirk and Kutchins 1992; Wilson 1993; and Appelbaum 1994). According to Appelbaum

(1994), psychiatrists used their authority to defend issues such as justifying abortion,

absolving people from the consequences of their actions, which had legal implications,

and defining people as disabled, which would entitle them to societal support. These

actions lead to questions about the power (Appelbaum 1994) and the legitimacy (Wilson

1993) consigned to the discipline of psychiatry in this country.

In addition to questions about the power and legitimacy granted psychiatry, new

developments in the law would limit their powers. These new developments are seen as

resulting from the civil rights revolution in the 1950s and 1960s (Appelbaum 1994; Burt

2001; Winick 2001), which emphasized the equal protection and due process clauses of

the Constitution. This new use and application of the equal protection and due process

clauses spread from the civil rights movement for Southern blacks to other disaffected

groups, such as people with mental illness. Implementation of the due process clause would require "a hearing before confinement, with notice of charges, the right to representation, and the right to appeal" (Appelbaum 1994: 10). There were also changes in state and district legislations that corresponded with legal developments. For example in California and Washington D.C. changed the justification for commitment from the need or benefit from treatment, to dangerousness to self or others. By the late 1960s, these events helped to set the stage for reforms in commitment laws for the mentally ill across the United States (Appelbaum 1994).

In the early 1970s, there were a number of court cases that affected how and why involuntary commitment should occur. First, in 1972 the U.S. Supreme Court expanded due process and equal protection to a criminal defendant who suffered from mental disabilities in *Jackson v. Indiana*, 1972. In this case, a criminal defendant was civilly committed for an undefined amount of time, in order to restore competency to stand trial. This defendant was hearing impaired, mute, and mentally retarded and the Court noted the extent of the defendant's problems and the lack of services received, in their ruling. The Court found that the defendant's commitment is tantamount to a life sentence, without holding a trial or commitment hearing and the due process clause allowed the state to hold the defendant only for a reasonable period, to determine whether or not the defendant could be restored to competency (Frost and Bonnie, 2001).

In the next case, *Lessard v. Schmidt* 1972, a federal district court in Wisconsin explicated a list of constitutional protections that must be followed before civil commitment occurs (Frost and Bonnie, 2001). The court ruled that the commitment statue absolutely necessitates that the person in question has such a potential for harming others

and/or his or herself that it justifies the restriction of liberty. Subsequently, the state bears

the burden of proving that the person in question is such a threat that if they are not

confined they will harm themselves or others. This evidence must be based on explicit

acts, attempts, or threats to harm themselves or others (Appelbaum 1994). This case

dramatically changed the standard for civil commitment and introduced a demanding set

of practices drawn from criminal law, which both reflected the ethos of the era and

helped shape commitment law. For example, this decision came about when states were

beginning to change their commitment laws towards the criteria of dangerousness to

one's self or others; however, this decision also represented a desire to undermine

psychiatric powers and therapeutic urges that had previously driven civil commitment

laws. Nevertheless, every state, by the end of the 1970s, either had changed its

commitment laws or interpreted existing statutes to conform to the dangerousness to

one's self or others criteria, expressed by the *Lessard v. Schmidt,* 1972 case (Appelbaum

1994).

The commitment history shows sweeping changes in the justification for

commitment during the community-based care phase. From a legal standpoint, the

justification for commitment changed from the need and benefit of treatment to

dangerousness to self or others. This understanding was based on the assumption that,

except for extreme cases, individuals had the right to seek and submit to treatments, for

mental illness, at their own discretion and not have it imposed on them from the state.

Subsequently, justification for commitment was more restrictive and shifted the burden of

proof to the states, for involuntary commitment. This corresponds to the change in the

conception of mental illness from psychotic or chronic; dominate prior to and during part

of the institutional phase of treatment, to the continuum conception of mental illness held during the later part of the institutional phase and the first 15 years of the community-based care phase. For example, the psychosocial model would suggest those with "less" mental illness would be competent enough to seek their own treatment and those with "more" mental illness could be subject to more restrictions, if they met the criteria.

Commitment Proceedings

The remarkable changes that took place in commitment laws, during the late 1960s and early 1970s, were designed as limitations to both states' and psychiatrists' power to commit people without due process. Appelbaum (1994) reviews the literature on the effects of these new commitment laws. He breaks the literature into three categories: studies using aggregate data, studies using individual data, and studies where people were not committed. Appelbaum (1994) asserts that it has been tough for researchers to establish that new laws have drastically changed or even reduced the number of commitments. For example, "[t]o the extent that consistent finding are available, they tend to show that the statues have had less impact than expected (and in some cases minimal effect) on overall rates of commitment and on the nature of committed populations" (40).

Despite extensive legal reforms, these findings lead to the question of why civil commitment rates did not decrease dramatically the number of commitments. Appelbaum (1994) suggests for over a century prior to the early 1970s participants in civil commitments worked together to hospitalize people with mental illness. Commitment now required evidence of explicit acts, attempts, or threats to harm themselves or others and now these participants were forced to change their behavior. In theory, this restrictive

nature of commitment was endorsed; however, in practice this endorsement did not hold up. Warren (1977) argues there was a "commonsense model" for determining commitment. If people whose hospitalization was in question were viewed as mentally ill then it was understood, they were not able to decide what was best for their lives. She describes a process referred to as "bargaining down" the initial commitment criteria. At initial hospitalization, a majority of patients were described as fitting the criteria of dangerousness to self, others, and having a serious disability; however, when seeking extended hospitalization patients were identified only as seriously disabled. This was seen as a bargaining process amongst participants in the civil commitment (Warren 1977).

Winick (2001) argues this practice has undermined the adversarial model of the judicial system. Attorneys tend to neglect the adversarial role and adopt a paternalistic role for civil commitment cases. This suggests attorneys relax their advocacy and impose their perception of what is in the mentally ill client's best interest, typically commitment. In addition to attorneys, judges adopt a paternalistic role and agree with expert witnesses from 79 percent to 100 percent of the time. The paternalistic outlook produces a system where procedural rights are used to achieve what judges, attorneys, and mental health professionals see as being what the patient needs (Winick 2001). Appelbaum (1994) summarizes why the new laws, that restrict civil commitment, did not have the dramatic effects anticipated, by suggesting participant in the mental health system are not passive actors; however, they modify their behavior in order to acquire the result they want.

Patient Release

Because of these vast structural changes that altered the location of care for the population with mental illness, patient release became contingent on the organization treating the person with mental illness. First, outpatient psychiatric clinics were typically not involved in the involuntary care of patients. The next organizational form was the psychiatric unit of general hospitals. The role of psychiatric units in general hospitals were to provide acute and short-term care for mental illness. This is problematic for individuals with chronic forms of mental illness because treatment may or may not stabilize the symptoms within the amount of time allotted for treatment (Kiesler and Simpkins 1993). For those with acute and chronic problems, they were allotted enough time to rehabilitate and be discharged. If there was no improvement then the patient would be transferred, to a state or county mental hospital, nursing home, or other long-term care facility and in some cases they were discharged without improvement. This new structural transition in inpatient care benefited those whose problems were acute; however, it ignored those with chronic and persistent mental disorders.

The second organizational form, the nursing home, had taken the role of providing long-term care for former patients of state and county mental hospitals (Bootzin and Shadish 1986). Bootzin and Shadish (1986) suggest from their research that if a resident with mental illness leaves the nursing home it is to be rehospitalized, however, this could include hospitalization in a general hospital as well as a psychiatric ward of a general hospital or state and county mental hospital. Moreover, they argue that very few leave the nursing home for independent living after they are admitted. They argue nursing homes are not transitional facilities that help individuals with mental illness

move back into the community. Finally, organizational forms that may or may not provide treatment are the jails and prisons, which, during this phase, are beginning to see more and more individuals with mental illness. These individuals are incarcerated until their sentence is complete, provided they do not have any additional time added because of actions taken while psychotic.

The Institutional Pillars

In this phase the cultural-cognitive element again changed; however, for different reasons than in the institutional phase. During the institutional phase the framework used to understand mental illness changed from a narrow understanding of mental illness as psychotic or chronic to a broader understanding of mental illness, which is exemplified by the psychosocial model. This model views the cause of mental illness as the interaction of individual psychological processes and environmental conditions (Wilson 1993). During the community-based care phase, the framework changed from the psychosocial mode back to a Kraepelinian form of classifying and biological or medical understanding of mental illness; however, it was fundamentally different than previous models.

Horwitz (2002b) asserts that, although often portrayed and described as antithetical, the psychosocial and biological models are much more symbiotic. Horwitz (2002b) argues that the use of the Kraepelinian nosology prior to the adoption of the psychosocial model restricted the number of diagnosis to a small number of brain impairment and psychotic disorders. However, after the discipline of psychiatry adopted and then discarded the psychosocial model and returned to the Kraepelinian nosology it kept the nonpsychotic disorders advocated by the psychosocial model. Instead of

discarding those disorders, "the DSM-III simply categorized behaviors that dynamic psychiatry [the psychosocial model] had already pathologized. It increased the number of specific illness conditions, not the behaviors to which the particular diagnoses referred" (Horwitz 2002b: 79).

Just as the cultural-cognitive frame used to understand mental illness changed, the understanding and determination of which treatments were legitimate changed too. This changing of treatments affects the normative pillar of the institution. However, the difference between the community-based care phase and the institutional phase was that the changing cultural-cognitive framework did not lead to structural changes to the location of treatment. The change in the cultural-cognitive framework helped to change the methods of treatment. For example, the psychiatric discipline once directed by the psychosocial model was now focused on biological and neurological explanations of mental illness. This biological orientation in psychiatry was rooted in the development and success of psychotropic medications introduced in the 1950s (Bond and Lader 1996; Engel 2008). In addition to medications, therapy itself changed from psychoanalysis to cognitive and behavioral therapies. Together cognitive and behavioral therapies were shown to have effective outcomes for certain diagnoses, such as nonpsychotic disorders (Engel 2008; O'Dwyer 1998). With the use of psychotropic medications and the complement of cognitive and behavioral therapies, treatments were specifically designed and used to treat explicit disorders, which fell in line with the Kraepelinian nosology (Horwitz 2002b). Moreover, these treatments—although mainly psychotropic medications—operated as a normative isomorphic force, which reinforced the cultural-cognitive understanding of mental illness as a biological in origin.

Finally, during this phase, increasing changes in the regulatory pillar of the institution provided coercive isomorphic forces, which influenced cultural-cognitive pillar. Specifically, third-party payers—both the federal government and private insurance companies—saw significant problems with reimbursements for mental health expenditures. This is because mental illness lacked standardized methods of assessment and treatment (Wilson 1993). Subsequently, these third-party payers began to require a closer relationship between diagnosis and treatment (Kirk and Kutchins 1992).

Similar to the previous chapter the cultural-cognitive conception of mental illness changed and this change affected the justification for treatment methods. However, the change in the conception of mental illness did not originate within a discipline challenged to appropriately treat the mentally ill during World War II. It originated within a discipline challenged by both coercive and normative isomorphic forces (third-party payers and the "success" of psychotropic medication). In fact during this phase, it appears that changes in the regulative and normative pillars of the institution did more to affect the changes in and cultural-cognitive pillar. This is different than the institutional phase where cultural-cognitive forces seemed to be the impetus for both the normative and the regulative change in the institutional pillars.

Conclusion

During this phase of treatment the conceptualization and classification of mental illness changed again; however, unlike the institutional phase this change was not a reaction to a problem that required a higher degree of treatment efficacy. It was generated by a crisis of legitimacy within the discipline of psychiatry. This crisis was the result of multiple sources; however, the end result was a conceptual shift that focused on the

description of specific disorders and the identification of specific symptoms. This resulted in increasing "the number of specific illness conditions, not the behaviors to which the particular diagnoses referred" (Horwitz 2002b: 79).

Although the conceptual understanding of mental illness changed during this phase, it did not change until the community-based care phase was almost at an end. This is important because as the data indicate the organizational structures used to treat mental illness began to change during the institutional phase and those structures began to treat (although not exclusively) specific types of disorders. Subsequently, the Kraepelinian conceptual understanding of mental illness did not have the structural implications for treatment as did the psychosocial conceptual understanding of mental illness in the previous phase. In fact, what the patient characteristics seem to indicate is that as the Kraepelinian method was implemented and symptoms began to represent distinct disorders, this nosologic change further reified treatment of nonpsychotic disorders. This finding supports Horwitz's (2002b) assertion of the two nosologies—psychosocial and Kraepelinian—are more symbiotic than previously thought. This symbiosis is not because of ontological agreement. However, it is because symptoms that were relevant under the psychosocial model were delineated under the Kraepelinian method.

Along with changes in the conceptualization of mental illness, there were changes in commitment history too. The justification for commitment changed from the need and benefit of treatment to dangerousness to self or others. This justification was based on an individuals' right to submit to treatments on their own accord and was more restrictive. This new justification shifted the burden of proof for commitment to the state and psychiatrists. However, despite the changes in the justification for commitment the rates

of commitments did not decrease dramatically. These changes did not have the affect on commitment rates because the participants in the mental health and legal systems modified their behavior in order to acquire commitment if they deemed it appropriate. In addition, there were changes in treatment patterns and theories. Once directed by the psychosocial conceptualization of mental illness, psychiatry was now guided by the biological and neurological understanding of mental illness. This was influenced by the success of psychotropic medications. In addition the use and type of nonmedical therapy changed from psychoanalysis to cognitive and behavioral therapies, because of the lackluster results produced by psychoanalytic analysis. These normative isomorphic forces had the affect of shifting psychiatry's practices towards the biological and medical forms of mental health treatment.

Where treatment occurs was dramatically affected in this phase by the institutionalization of new organizational forms in the previous phase. The coercive isomorphic forces such as Medicare and Medicaid lead a fragmented institution of mental health care. The structural changes are shown in the data, which indicated that inpatient care episodes in state and county mental hospitals were surpassed by non-federal general hospitals and with the incorporation of outpatient services there was a vast increase in the total number of care episodes for mental illness. We see the dramatic increase in care episodes, from 1.7 million in 1955 to 6.4 million in 1975 (Taube and Redick 1975) to 7.4 million in 1986 (Redick et al. 1990). There is also evidence that nursing homes played an important role in long-term inpatient care in two waves. First, is the transinstitutionalization of state and county mental patients to the nursing home in the earlier part of the phase and second is the large increase in mental illness in the later part

of the phase, which could be the result of the use and implementation of the DSM-III. Finally, although the rates of incarceration are hard to determine within the literature, prisons and jails began to confin more people with mental illness. Moreover, these organizations had different standards regarding patient discharges. Patients' release became contingent on the organization treating the person with mental illness. This transition in inpatient care benefited those with acute problems and placed a treatment burden on those with chronic and persistent mental disorders.

In conclusion, using neoinstitutional theory, this chapter shows the importance of all three institutional pillars and their isomorphic forces on the framework used to understand specific social problems addressed by an institution. These three pillars are the foundation for institutional stability or change of its organizational structures and the roles people assume. Unlike the institutional phase no new structural elements were institutionalized. However, during this phase the organizations used to treat people with mental illness, which were institutionalized in the previous phase, began to transition and took over the role of state and county mental hospitals. This change had important implications for treatment of mental illness, the transition from one organizational form (inpatient) to another (outpatient) and the changing cultural cognitive conceptualization of mental illness facilitated the vast increase in use of mental health treatment. Moreover, which category of diagnosis you fell under had an enormous influence on where you were treated. Finally, the cultural-cognitive conception of mental illness was changing; however, it was not driving the process, unlike the previous phase. Both coercive and normative forces seemed to change how mental illness was conceptualized during this phase.

Chapter 6. The Mental Illness Treatment Career during the Managed Care Phase

This chapter covers treatment careers of people with mental illness during the managed care phase (1985-2005). Using a modified version of Gove's (2004) framework, changes within the organizational field and the effects they have on mental illness careers are described. Similar to previous chapters, this allows the mental illness career to be understood within organizational context and change. First, this chapter focuses on who was considered mentally ill during this phase, which requires understanding how mental illness was classified and the patient characteristics that were important for treatment. Second, the chapter focuses on the structures of treatment, why it begins, takes place, and ends for people with mental illness. Describing the mechanisms involved, and structures used to engage people with mental illness in treatment, demonstrates the effect organizational context and change has on treatment careers. This chapter ends with an explanation of the mental illness career during the managed care phase though the lens of neoinstitutional theory, which allows for the interpretation of the consequences organizational context and change have on patients' treatment engagements and their subsequent treatment careers.

Socio-Political-Economic and Historical Context of the Mental Illness Career

The historical context engendered by Post Fordism continues throughout this treatment phase. Specifically, economic and ethical concerns that challenged federal intervention came to fruition in this treatment phase. During this treatment phase large corporations have risen to dominate economic life, and, the medical profession has lost its sovereignty. Prior to the managed care phase medical experts decided which services were necessary to treat specific disorders; however, after the implementation of managed

care, through different mechanisms, these experts' decisions came under increasing scrutiny. These mechanisms were designed to reduce health care expenses and costs (Mechanic 2008; Wells et al. 1995). Ironically, the idea that took root was that government policies designed to create more equity (i.e., Medicare and Medicaid) undermined the medical profession's power. However, Star (1982) asserts that this idea was erroneous. The threat to professional power came from private insurers, employers, and public programs wanting controls placed on medical expenditures (Star 1982).

Although more subtle, the changes that occurred during the managed care treatment phase—1985-present—have had as significant effects on the treatment career of people with mental disorders as deinstitutionalization. Coercive mechanisms employed by private insurers, employers, and public programs further emphasized the institutional logic of community-based care, where treatment was pushed further into community organizations, such as outpatient settings and local inpatient settings. This community-based logic had important implications for people with mental illness. In general, by pushing care further into the community, managed care practices have made access to mental health services easier. This community-based structure benefits those with acute and/or personal problems whose problems are episodic; however, people with serious and chronic mental illness do not benefit because this structure neglects problems that require long-term resolutions and organizational forms designed for long-term treatment (Mechanic 2008).

Categorizing Mental Illness

Unlike previous phases, the managed care phase has seen little change in the psychiatric nosology. However, the DSM-III changed psychiatric nosology from a focus

on etiology to a description of symptoms. The balance of power in American psychiatry shifted from those who conceptualized mental illness through the psychosocial framework to those using a Kraepelinian nosology. The success of descriptive or Kraepelinian psychiatry was that it resolved the crisis of legitimacy the discipline of psychiatry was going through. Despite this intellectual tumult, no abrupt structural changes accompanied the change in cultural-cognitive conceptions like the changes that followed the ascendance of the psychosocial conception of mental illness and deinstitutionalization. This lack of sudden change has to do with how psychiatry negotiated its return to the Kraepelinian nosology. First, psychiatry kept nonpsychotic disorders advocated by the psychosocial model. Keeping these disorders made it easier for practitioners who were used to the psychosocial conception of mental illness to accept the new nosology. Second, breaking these aforementioned disorders into distinct diagnostic categories enabled the community-based care logic to remain relevant. Had nonpsychotic disorders been stricken from the DSM-III it would have undermined the treatment model that was central to the community-based care logic. The treatment model central to the community-based care logic included the idea that if a mental illness was caught early enough it could be successfully treated.

After the development and implementation of the DSM-III, psychiatric nosology did not see much change. Subsequent editions of the DSM have served to further reify Kraepelinian nosology (Mayes and Horwitz 2005). However, despite psychiatric nosology not seeing much change since the 1980s, versions of the DSMs have (Kirk and Kutchins 1994; Rogler 1997). However, most of these changes have to do with clarification of disorders and do not alter the nosology used (Galatzer-Levy and Galatzer-

Levy 2007; Rogler 1997). Delineating disorders into subcategories of a disorder or entirely new disorders has had a strong influence on the DSM's expansion (Rogler 1997). According to Rogler (1997), DSM-IV attempted to limit growth through empirical methods such as literature reviews, data analysis, and field trials. However, the DSM continues as a collection of hypotheses approaching the classification of abnormal behavior and "many of these hypotheses center on an observational theory of disorders as bounded entities" (Rogler 1997:13). Some researchers question the utility of the DSM suggesting it obscures, rather than facilitates, communication about mental illness and as a result, hinders new treatments (Galatzer-Levy and Galatzer-Levy 2007). Others argue that current research questions the validity of a dichotomous classification (Craddock and Owen 2007).

Nevertheless, the American Psychiatric Association is developing the next DSM 5, scheduled to appear in 2013, without changing the descriptive nosology. After DSM-III, the use of a descriptive nosology created a "biological default" (Mayes and Horwitz 2005: 265). This default favors the biological approach to explaining and treating mental illness as some form of brain or neurological malfunction. Consequently, when reviewing the data during this phase, we should see a continuation of trends that began to develop during the community-based care phase, which is a further emphasis of community-base care.

Patient Characteristics

Figure 30 shows the dramatic effects of deinstitutionalization policies from the 1960s to the mid 1980s. After 1980, deinstitutionalization began to slow. However, residents of state and county mental hospitals continued to decrease in number. The

majority of patients had psychotic disorders with nonpsychotic disorders and brain impairment making up a smaller portion of the patient population. Data suggest the trend of deinstitutionalization continued throughout this phase and appears to have leveled out slightly from 2000 to 2005. Nonetheless, the majority of cases in state and county mental hospitals experience some type of psychotic disorder.

Figure 31. Total Number of Resident Patients in State and County Mental Hospitals at End of Year and by Type of Disorder 1950 to 2005
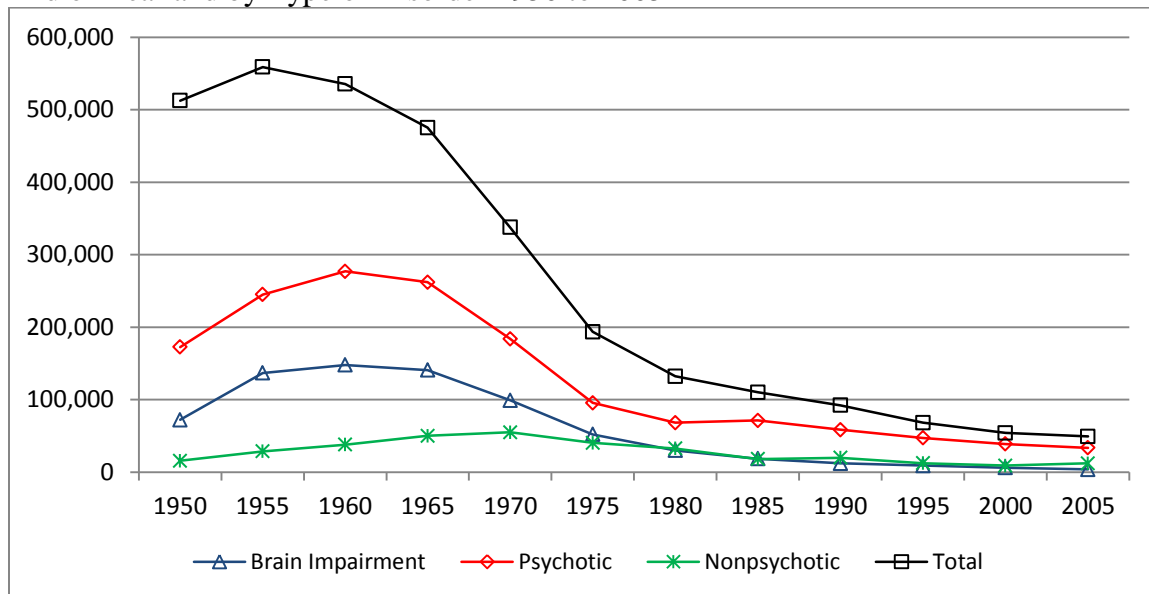
Source: *Patients in Mental Institutions* 1947-1965 and Data from National Institutes for Mental Health 1970-2005

Coupled with the overall trend in deinstitutionalization, Figure 32 shows psychotic patients continued to be the main focus of state and county mental hospitals during this time, making up around two thirds of the patient population from the years 1985 to 2005. Resident patients in state and county mental hospitals with nonpsychotic disorders remained relatively constant at approximately 20 percent over this twenty-year period. However, more variability existed in the proportion of nonpsychotic residents than residents with psychotic disorders. Unlike psychotic and nonpsychotic disorders, which seemed to settle into relatively consistent proportions, brain impairment continued

its consistent decline making up less than 10 percent of the 49,000 resident patients in 2005. In addition, Figure 32 does not indicate any significant changes in the nosology of mental illness, such as those occurring in the early 1950s (with DSM-I) and early 1980s (with DSM-III).

Figure 32. Estimated Percent of Resident Patients at End of Year in Public Mental Hospitals by Disorder Type 1985 to 2005
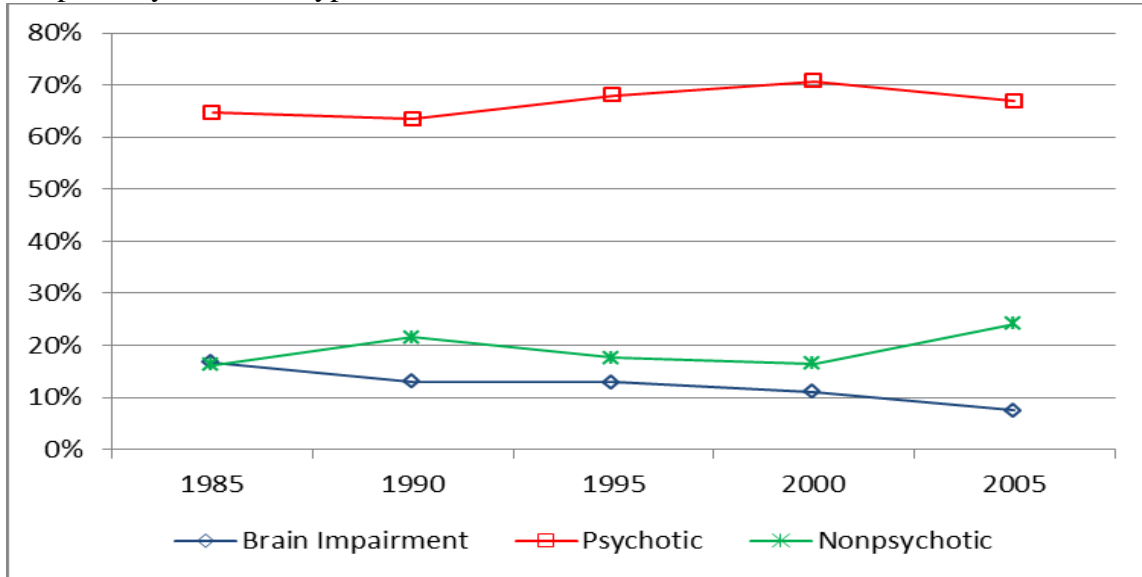
Source: *Patients in Mental Institutions* 1947-1965 and Data from National Institutes for Mental Health 1970-2005

Similar to previous findings in this chapter, Figure 33 also shows changes in type of patients' characteristics that were important for treatment in short stay hospitals. Up until the late 1970s, nonpsychotic disorders were the main focus of the short-stay hospitals; however after 1980 this changed and the focus slowly began to shift toward psychotic disorders. Since 1980 psychotic disorders have consistently increased, while nonpsychotic disorders have consistently decreased, in the proportion of patients discharged from short-stay hospitals. Both types of disorders level off in 2001 to 2004 and then continue after 2004. Figure 33, similar to Figure 32, also demonstrates the consequence of the development and reification of DSM-III, and its subsequent revisions,

over 26 years. I argue that, coupled with Figure 32, these figures show how the mental health sector's emphasis changed from nonpsychotic to psychotic disorders. Thus, during this quarter century, the inpatient sector gradually began to focus on, and provide treatments for, patients with psychotic disorders, and, began shifting away from treating patients with nonpsychotic disorders.

However, Fisher et al (2001) point to an alternative explanation arguing that expanded inpatient private insurance benefits allowed psychiatric units of general hospitals to be selective of who they took as patients. Subsequently, psychotic patients were ignored in favor of nonpsychotic patients. As a result, by the 1990s, managed care organizations constrained the use of inpatient services for patients with nonpsychotic disorders, which had the effect of pushing the general hospital into treating more patients with psychotic disorders. Although a plausible explanation, I argue it is not the reason why patients' characteristics changed over time in short stay hospitals. First, the timing of the change is too coincidental with Figure 33 indicating a change starting in 1981, the year after the implementation of the DSM-III and the neo-Kraepelinian nosology. Second, and concomitant with the first reason, the same pattern expressed in Figure 30 shows nonpsychotic disorders decreased in importance and psychotic disorders increased in importance after the implementation of the DSM-III. Finally, this trend of ignoring psychotic patients and attending to nonpsychotic patients has been reported to occur in organizations (i.e., community mental health centers) that would not have been affected by managed care or private insurance practices in the 1980s (Grob 1991a; Grusky et al. 1985; Mechanic 2008). Figure 2 shows the percentage of nonpsychotics first admissions to state and county hospitals in 1972 was about 70 percent. These facts seem to point

toward the conception of mental illness as a source of change more so than funding

mechanisms used in mental health sectors.

Figure 33. Percent of Patients with a Diagnosed Mental Disorder Discharged from Short-Stay Hospitals by Selected Diagnostic Categories 1979-2005[9]
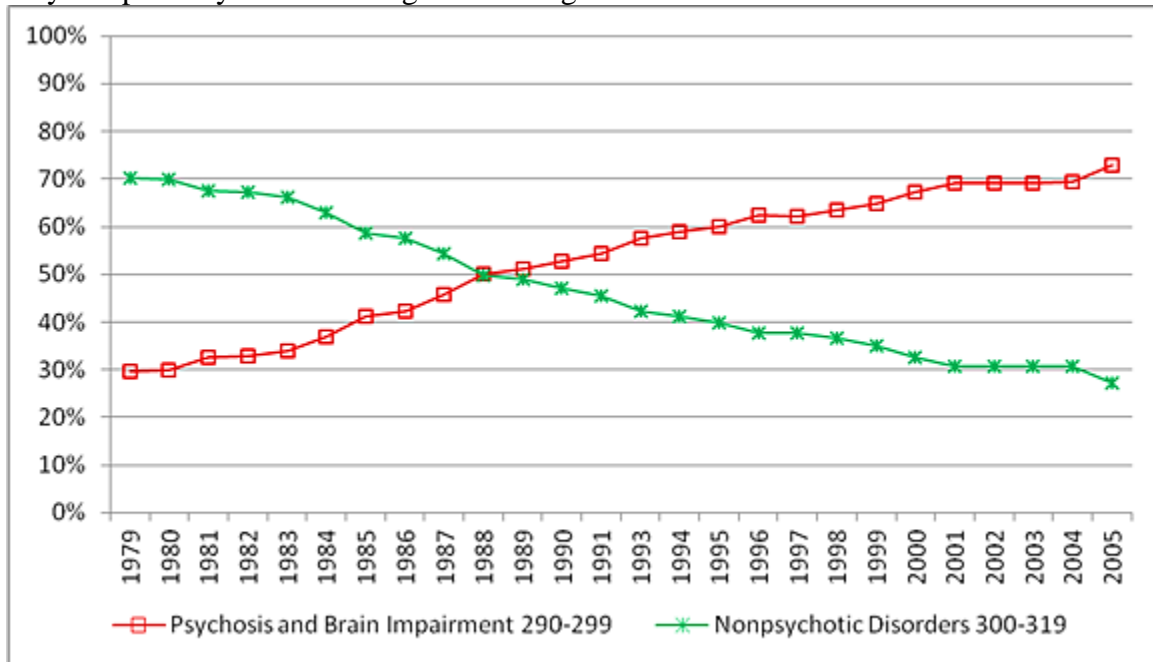
Source: *Utilization of Short-Stay Hospitals: Annual Summary for the United States*, 1979-1986 and *National Hospital Discharge Survey: Annual Summary*, 1987-1991 and 1993-2005

Data on nursing homes in Figure 34 show that the number of brain impairment

disorders decreased considerably over the twenty-seven years measured, while psychotic

and nonpsychotic disorders increased over this time. If, however, as was suggested in the

previous chapter, the nursing home's role in the treatment of mental illness was to

provide a residential facility for old people, whose primary diagnosis was typically a

severe condition such as brain impairment and psychosis, why would the diagnosis of

brain impairments decrease and other mental illnesses increase over time? Moreover,

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[9] Nonpsychotic disorders included mental retardation, which is typically included in brain impairment disorders in most figures

these data show that the number of psychotic and nonpsychotic disorders has consistently

increased from 1977 to 2004.

Figure 34. Number of Nursing Home Residents, by Primary Diagnosis of Mental
Disorder at Admission and at Time of Survey
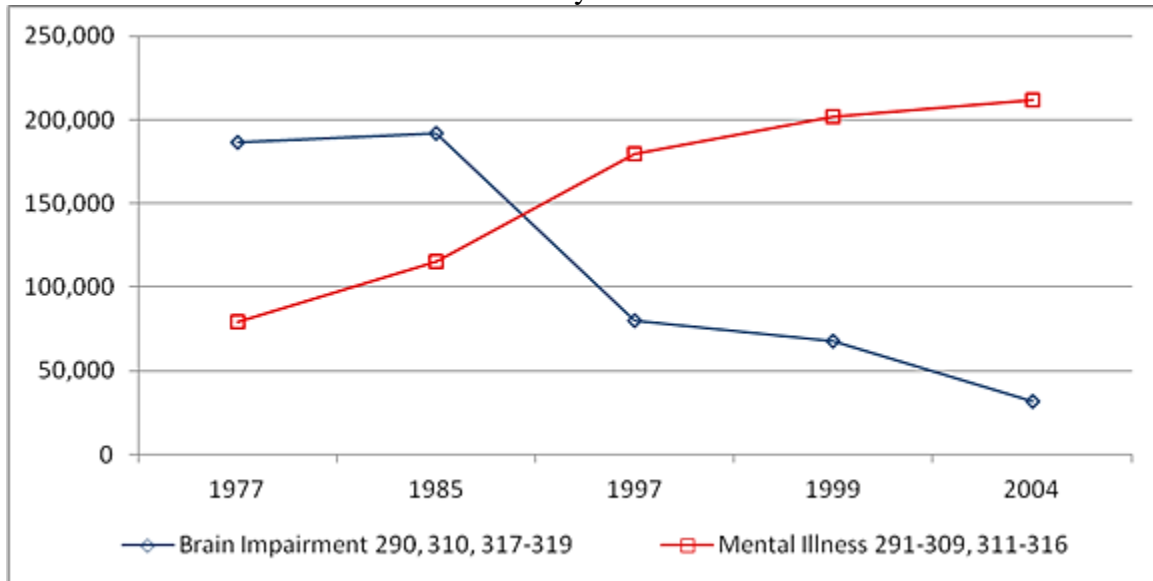
Source: The National Nursing Home Survey 1977-2004

Figure 35, however, sheds some light on the question of the nursing homes

treating brain impairment. In 1985, The National Nursing Home Survey added a category

to include disorders such as Alzheimer's disease, Parkinson's disease, Multiple Sclerosis,

and other diseases of the nervous system and sense organs, problems that can lead to

dementia. As brain impairment disorders decreased, these diseases and disorders

increased, suggesting that brain disorders have been reclassified and are now identified in

more discrete diagnoses. Fox (1989), who focused on Alzheimer's disease, documented

this reclassification and explains how the Alzheimer's diagnosis went from rarely being

applied to being one of the top five causes of death in a little over a decade. Prior to the

1970s, Alzheimer's disease was seen as a pre-senile form of dementia reserved for

individuals aged 40 to 60 years and senile dementia was typically reserved for individuals

after the age of 60 or 65 years. The elimination of the age of onset between Alzheimer's

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and senile dementia was a reconceptualization of two distinct disorders and the expansion

of a medical category, into Alzheimer's disease. This reconceptualization and expansion

of Alzheimer's disease facilitated the establishment of a social movement that promoted

awareness, and implications of, the disease (Fox 1989).

Figure 35. Number of Nursing Home Residents, by Primary Diagnosis of Diseases of the
Nervous System and Other Sense Organs Plus Brain Impairment at Admission and at
Time of Survey
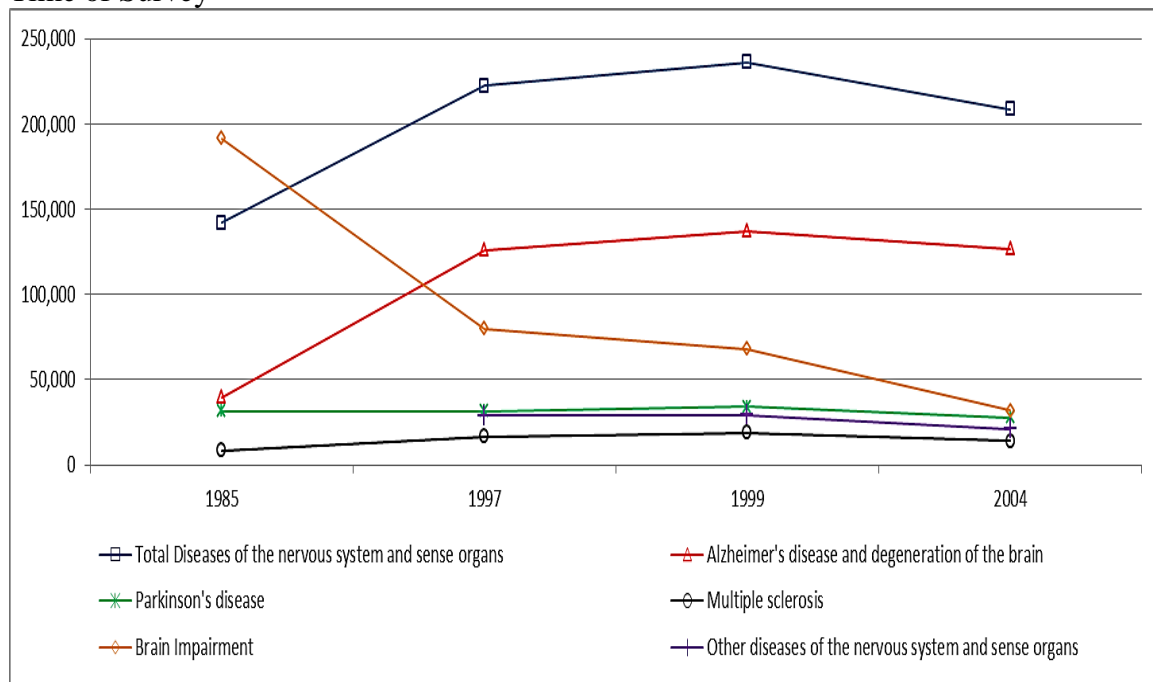
Source: The National Nursing Home Survey 1985-2004

When examining the data from The National Ambulatory Medical Care Survey

(Figure 36), over an 18-year period, the overall trend has been to increase office

treatment visits for both psychotic and nonpsychotic diagnoses, however, both types of

disorders remain relatively consistent in their composition of annual visits overtime.

Again, this seems to indicate that nonpsychotic disorders were the primary disorders

attended to by ambulatory visits. When examining Figure 37, which represents the

Annual Number of Ambulatory Care Visits by Diagnosis Group, we see that out of 27.1

million visits to ambulatory service sectors, general physicians and mental health

specialists in private practices were locations where a majority of visits occurred.

Additionally, as suggested in Figure 36 patients with nonpsychotic disorders were the

dominant demographic using services across the ambulatory sector.

Figure 36. Annual Number of Ambulatory Care Visits by Diagnosis Group
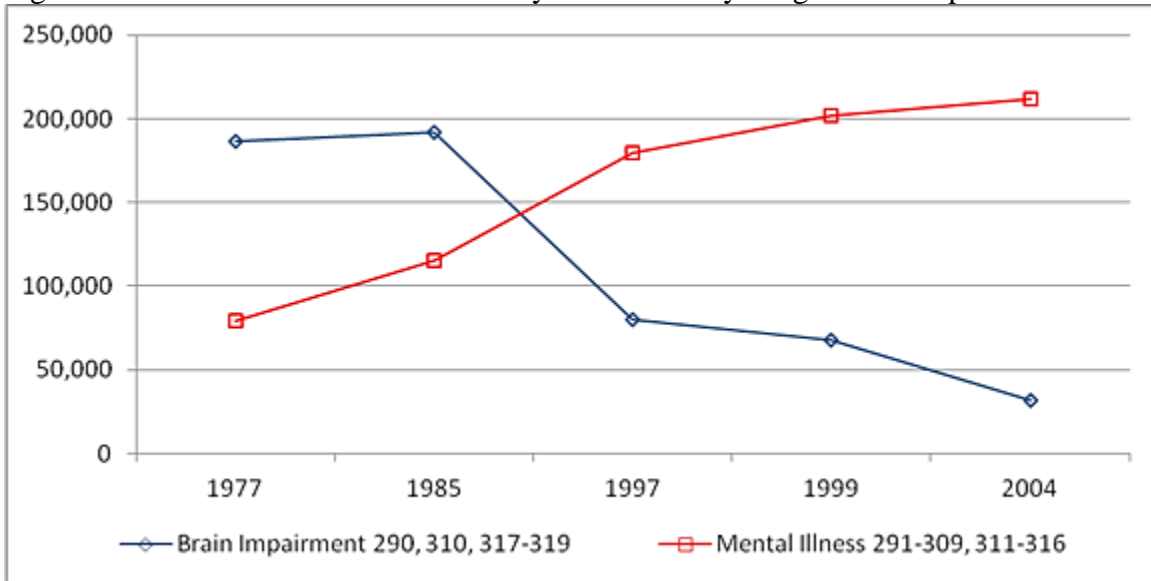
Source. Ambulatory Medical Care Utilization Estimate 1995-2007

Figure 37. Ambulatory Service Sectors: Distribution of Persons and Visits by Disorders
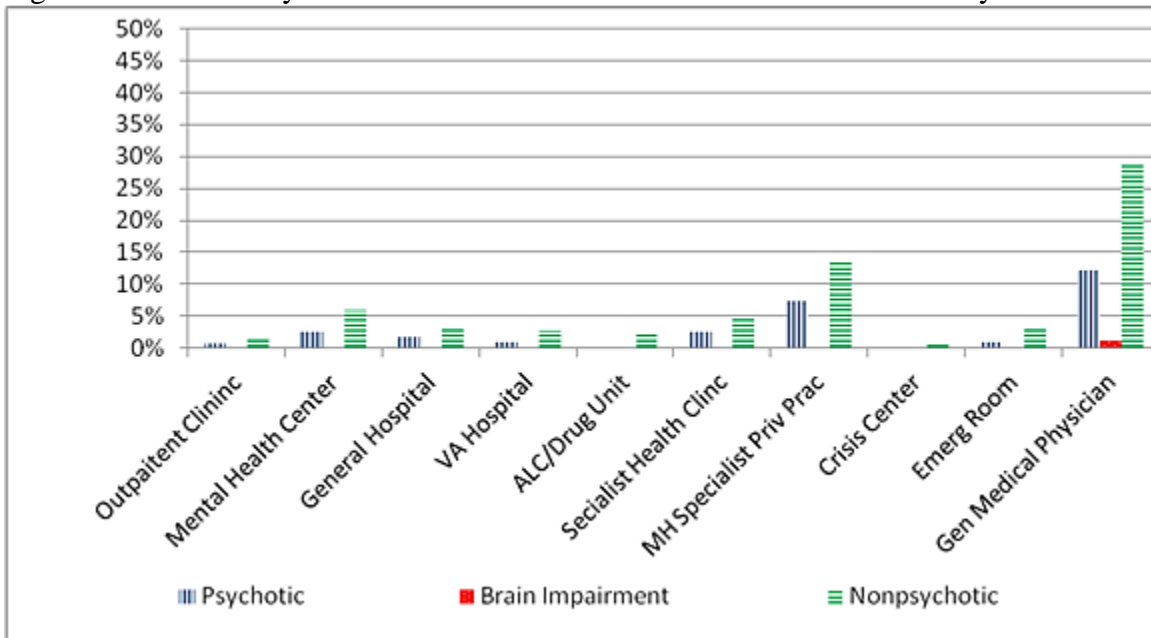
Source, Mental Health 1994

As indicated in the previous chapter, prisons have become an important location for mental health treatment. Examining Figure 38, Figure 39, and Figure 40 show the percent of inmates receiving one of three types of treatment: inpatient, residential, and counseling or therapy. Inpatient treatments included mental health care provided in a 24 hour a day facility with medical or nursing services and did not include prison infirmaries or drug or alcohol services (Swanson, Morrissey, Goldstrom, Rudolph, and Manderscheid 1993). Figure 38 denotes the percentage of inmates receiving inpatient care by primary diagnosis were predominantly those with psychotic disorders, followed by those with nonpsychotic disorders. This trend of inmates with psychotic disorders being the dominant users of inpatient services parallels the trend within the specialty mental health sector.

Figure 38. Percent of Prison Inmates in Inpatient Psychiatric Care by Primary Diagnosis in 1988
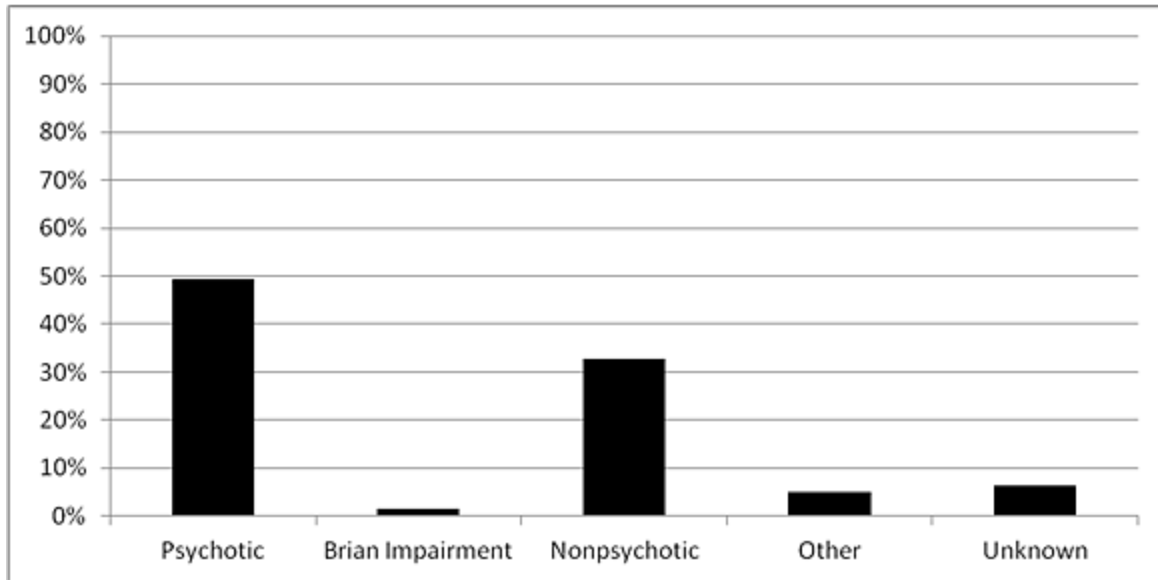
Source. Swanson et al. (1993) Demographic and Diagnostic Characteristics of Inmates Receiving mental Health Services in State Adult Correctional Facilities: United States, 1988

Residential treatments included mental health services in combination with special living arrangements such as therapeutic communities; halfway houses for inmates

with mental health problems; and units for sex offenders, violent inmates or those with

mental problems (Swanson et al. 1993). Figure 39 indicates that inmates involved in

residential treatment programs were those with both nonpsychotic and psychotic

disorders with the latter representing slightly more in programs. It would be expected that

inmates with psychotic disorders would dominate residential treatments; however, prison

officials have concerns other than the severity and chronicity of an inmate's symptoms.

These concerns can reflect the need to protect inmates with severe and chronic forms of

mental disorder as well as from other inmates.

Figure 39. Percent of Prison Inmates in Residential Treatment Program by Primary
Diagnosis in 1988
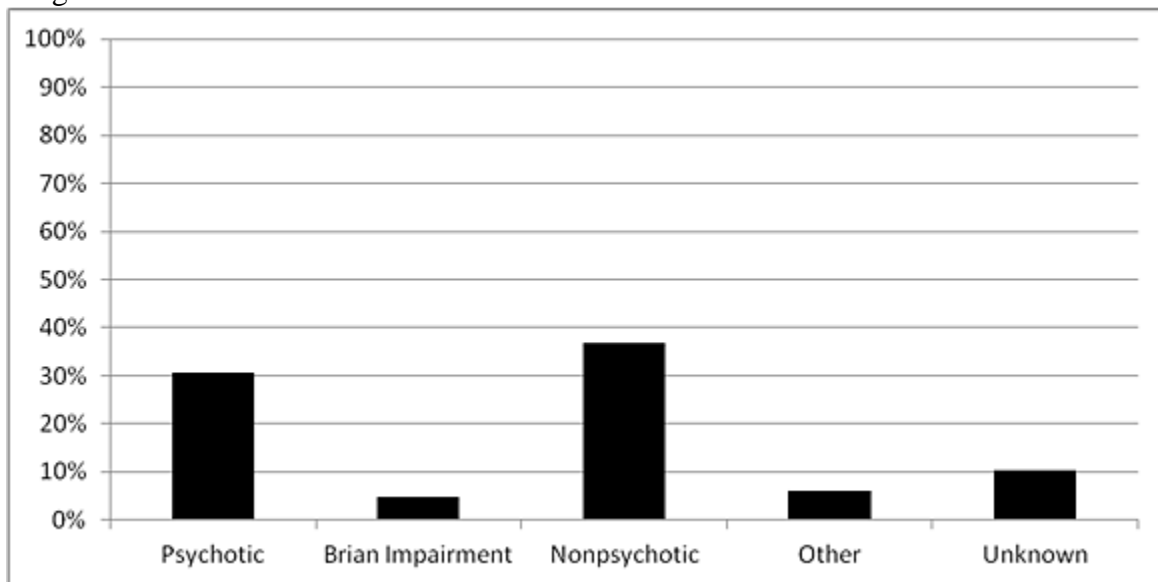
Source. Swanson et al. (1993) Demographic and Diagnostic Characteristics of Inmates
Receiving mental Health Services in State Adult Correctional Facilities: United States,
1988

  Finally, counseling or therapy services were provided to inmates not using

inpatient or residential treatments who were on an arranged or walk-in system. This

service was provided for individuals, groups, or families (Swanson et al. 1993). Figure 40

reveals that inmates with nonpsychotic disorders were the prominent users of counseling

and/or therapy services. This also mirrors the mental health sector, where persons with nonpsychotic disorders typically used ambulatory or walk-in therapies.

Figure 40. Percent of Prison Inmates in Counseling/Therapy by Primary Diagnosis in 1988
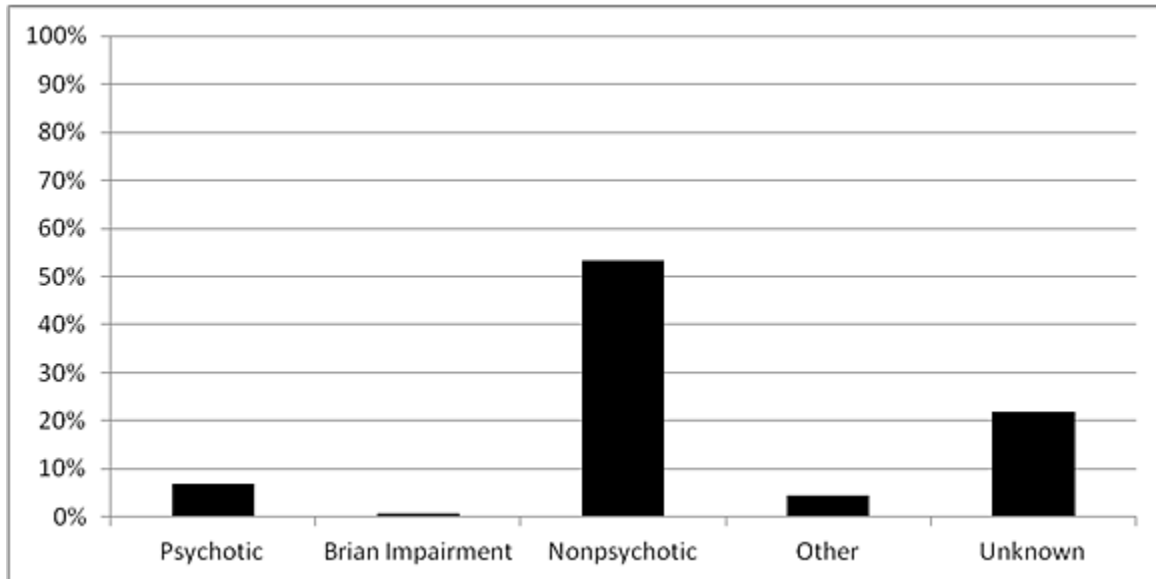
Source. Swanson et al. (1993) Demographic and Diagnostic Characteristics of Inmates Receiving mental Health Services in State Adult Correctional Facilities: United States, 1988

Unlike the previous two phases (institutional and community-based care), this phase is not characterized by significant changes in the cultural-cognitive element, which impacts the way, and to whom, treatment is provided. What changed was the increased use of the non-specialty mental health sector to treat those with mental illness. Thus, treatment occurred in specialty and non-specialty mental health sectors. For the specialty mental health sector, evidence suggests the occurrence, when examining patient diagnostic characteristics over this phase, of a "sedimentation" process. This shifted patients into different forms of treatment based on their diagnosis, those with nonpsychotic disorders were funneled into outpatient or ambulatory care and those with psychotic disorders were funneled into inpatient care. This sorting process, which began in the community-based care phase, was accelerated during the managed care phase.

Moreover, this sorting process appears to have been mimicked within the non-specialty mental health sector. Similar to the specialty mental health sector, the non-specialty mental health sector sorted patients with nonpsychotic disorders into ambulatory forms of care compared to those with psychotic or brain impairment disorders. Additionally, in the prison system, if inmates received any treatments, people with psychotic disorders tended to receive acute inpatient care while those with nonpsychotic disorders received outpatient or ambulatory care. One notable change during this phase was the rapid decrease in nursing home patients diagnosed with brain impairment disorders. As discussed earlier, it appears this was the consequence of brain impairments being reclassified or further delineated. Nevertheless, the function of the nursing home, to deal with patients who have brain impairments within the mental health sector, has not changed. The change has been the reclassification of disorders that seek biological oriented cures and treatments; however, this reclassification does not stray from the DSM's conceptualization of mental disorders.

Treatment Patterns and Theories

By the mid-1980s the shift from a psychosocial understanding to the Kraeplelinian or discrete understanding of mental illness was complete and this shift was significantly important for treatment. First, it provided a common language for treatment professionals, researchers, and third-party payers to define and discuses mental disorders. Next, it changed the power structure of the psychiatric profession by placing researchers above clinicians because researchers developed medically oriented treatments (a consequence of the biological assumption underlying Kraepelinian nosology) while clinicians used counseling (Mayes and Horwitz 2005).

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Another consequence of the biological assumption was further delineation of psychiatric roles in relation to other mental health professionals. For example, medically trained psychiatrists were tasked with the distribution of psychotropic medications, whereas other disciplines were responsible for counseling and psychotherapy (Mayes and Horwitz 2005). Moreover, psychiatric training changed with an emphasis in neuroscience and psychopharmacology. Clinical psychology has increasingly used behavioral and cognitive therapies while social workers increasingly focus on coping mechanisms and social supports (Mechanic 2008). However, a majority of therapists use the "best" components from multiple approaches to form an eclectic treatment style (U.S. Department of Health and Human Services 1999). In addition to further delineation of disciplinary roles during this phase, another change included quantity of psychotherapy provided with evidence suggesting that counseling and psychotherapy have increasingly been neglected as a component of mental health treatment, whereas use of psychotropic medications has increased (Mechanic 2008).

Finally a third change brought on by the biological assumption underlying the DSMs published after 1980 included physical therapies performed by psychiatry. By and large, these included psychotropic medications that benefited from increased funding in biological research prompted by the DSM-III's discrete conceptualization of mental illness. Moreover, the standardization of the DSMs enabled pharmaceutical companies to target products for specific mental disorders (Mayes and Horwitz 2005), an FDA (Federal Drug Administration) requirement in clinical trials (Horwitz 2002b). According to Mayes and Horwitz (2005), this standardized taxonomy had "unintentionally positioned psychopharmacology on a growth trajectory that various institutions—insurance

companies, managed care organizations, pharmaceutical companies, and the government—propelled significantly in subsequent years as they responded to the DSM-III's new diagnostic guidelines and the research incentives that it fostered" (266). Over the twenty-years of the managed care phase there have been numerous psychotropic medications introduced to treat mental disorders. These medications were the product of increased funding and research in neuroscience and molecular biology (U.S. Department of Health and Human Services 1999).

Now psychotropic medications are the most common form of treatment for adults with mental health problems. The most commonly prescribed psychotropics were anxiolytics, sedatives, and hypnotics, with antidepressants, antipsychotics, and antimanics following, respectively (SAMHSA 2010). Additionally, the single largest element of Medicaid's mental health budget includes psychotropic medications (Mechanic 2008: 19). According to *Mental Health, United States* (2008) the amount of psychotropic prescription medications filled by non-institutionalized individuals has more than doubled from 1996 to 2006 (121 million to 274 million fills for psychotherapeutic medications). Between 1996 and 2005 in the U.S, Olfson and Marcus (2009) found that the number of people treated with an antidepressant medication during the course of one year increased from about 13.3 to 27.0 million people. This number represents a significant increase in use of prescription drugs (SAMHSA 2010) and is closely related to normative beliefs regarding treatments for mental illness. These normative conceptions are driven by a discrete conceptualization of mental disorders.

Where Treatment Occurs

During the managed care phase, the structure continues to change; however, changes have been less radical and subtler than in previous phases. For example, there has been no concerted effort to change where mental health treatment occurs as there was during the community-based care phase. The structure of treatment continues to change with continued emphasis on providing community-based treatments while simultaneously decreasing patient numbers and costs associated with inpatient hospital treatment. Associated with this change was the fact that treatments most often received by adults in specialty mental health services were prescription medications followed by outpatient services. Specialty outpatient mental health services are an important component of the mental health care sector and include mental health clinic services as well as services from private therapists in office settings. Services that are least likely to be used in specialty mental health care include inpatient treatments or residential mental health services. Since the mid-1980s inpatient capacity has continued to decrease with psychiatric beds steadily decreasing by about 20 percent. However, some evidence suggests that general hospital beds are being used more frequently to treat mental illness (SAMHSA 2010).

As noted in the previous chapter, within the specialty mental health sector, outpatient treatment was the dominant treatment form and did not change during this phase. Moreover, Figure 25 in chapter 5 shows the importance of outpatient treatments after deinstitutionalization occurred. After the mid-1980s, outpatient treatments continued to increase in magnitude up until the last five years of this phase (Figure 41). Toward the end of this phase, outpatient treatment began to decline. It remains to be seen if this trend

of decreasing patient care episodes will be sustained over time (CMHS 2006). Figure 41 also shows inpatient care episodes slightly increasing, but this increase is small compared to the increase in use of outpatient treatments.

Figure 41. Percent of Patient Care Episodes by U.S. Population within the Specialty Mental Health Sector by Type of Mental Health Organization 1986-2002
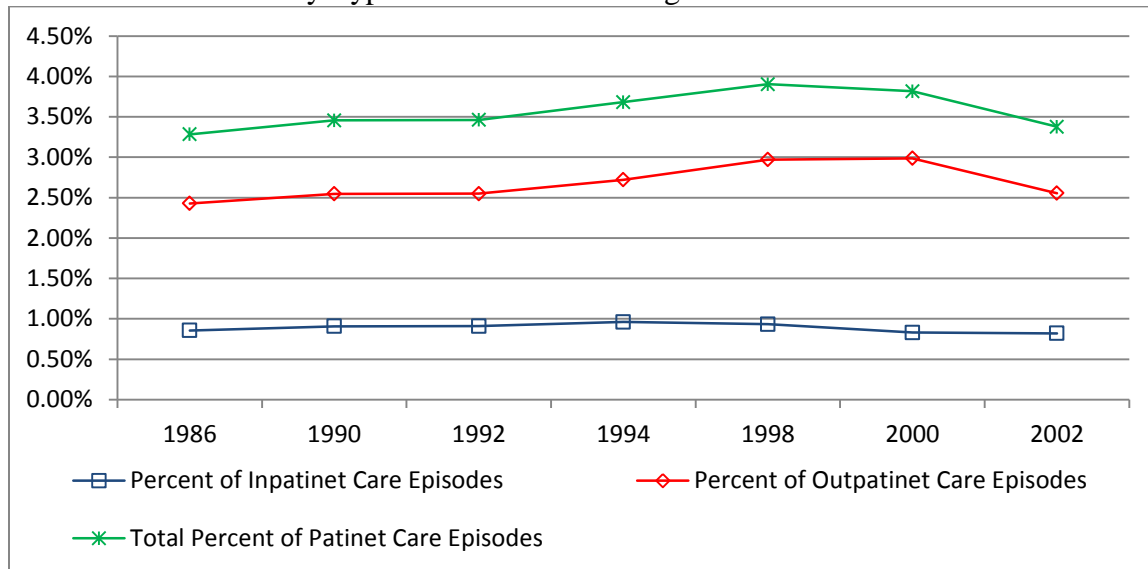
Source. Mental Health, United States 2004

Predictably, Figure 42 shows that in the 1980s and 1990s, the two organizational forms central to the community-based care movement increased substantially. The increase of these organizational forms (psychiatric wards of general hospitals and independent psychiatric outpatient clinics and other organizations) was important to the continued transition in logics from the institutional phase to the community-based care phase, which continued in the managed care phase. These organizational forms facilitated treatment in the community and reduced inpatient stays. Moreover, this transition in logics reduced use, as well as, prevented inappropriate placement of patients in state or county mental hospitals. However, a trend, specifying decreases in these organizational forms between 1998 and 2002, appears to be concomitant with the decrease in outpatient care episodes in Figure 41. Additionally, the number of psychiatric wards in general

hospitals also decreased between over these four years; however, inpatient care episodes, although showing slight decreases, did not shrink in the same manner that outpatient care episodes did.

Figure 42. Number of Mental Health Organizations Offering Services 1986-2002
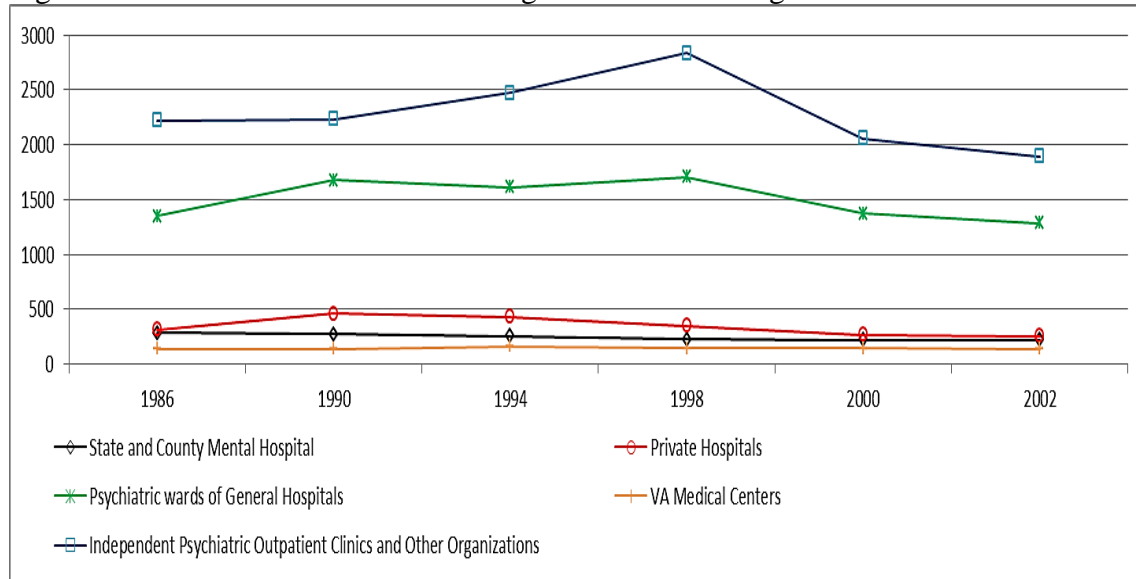
Source. *Mental Health*, United States 2004

Despite Figure 41 showing a decrease in the number of patient care episodes after 2000, and Figure 42 showing a decrease in the number of outpatient organizations after 1998, Figure 43 and Figure 44 show that for most organizations, both outpatient and inpatient, admissions increased in mental health organizations after 2000. Although speculative, this could be a consequence of consolidation of organizations or managed care practices restricting types of care episodes that are billable. Thus, the increase in admissions could be an adaptive organizational response, or, a consequence of demographics because more people are seeking treatment. Nevertheless, admissions to both outpatient and inpatient mental health organizations demonstrate the continuation of trends that began in the community-based care phase. The first trend that began in the previous phase and continued into the managed care phase was continued importance of

independent psychiatric outpatient clinics and other organizations. This organizational

form continued to be the dominant location, within the specialty mental health sector, for

outpatient mental health treatment; psychiatric wards of general hospitals were the next

important organizational form for outpatient treatments (Figure 43).

Figure 43. Number of Admissions to Outpatient Mental Health Organizations United
States, 1986–2004
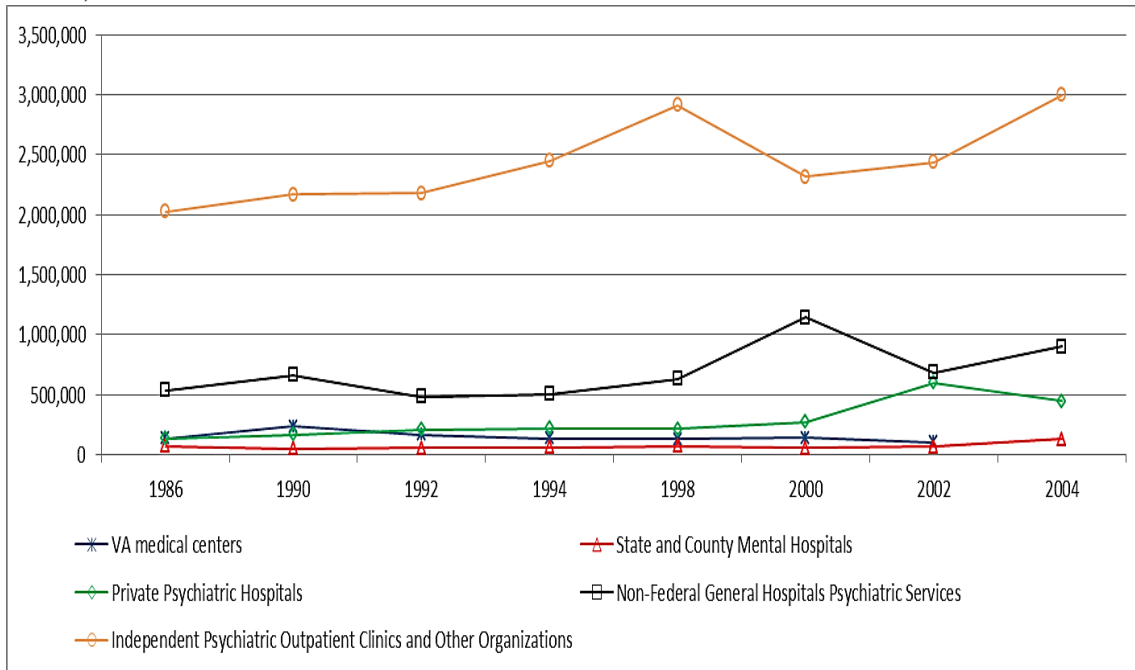
The second trend was the continued importance of psychiatric wards of general

hospitals that facilitated shorter hospital stays. Psychiatric wards of general hospitals

were the organizational form with the second highest number of admissions for outpatient

treatment, and, continued to be the dominant organizational form in inpatient treatment.

This organizational form was used to stabilize the patient and get him or her back out into

the community. The next most important organizational form of inpatient admissions

included private psychiatric hospitals. All other organizations constituted a relatively

small number of inpatient admissions further demonstrating the effects of

deinstitutionalization on state and county hospitals (Figure 44).

Figure 44. Number of Admissions to Inpatient Mental Health Organizations United
States, 1986–2004
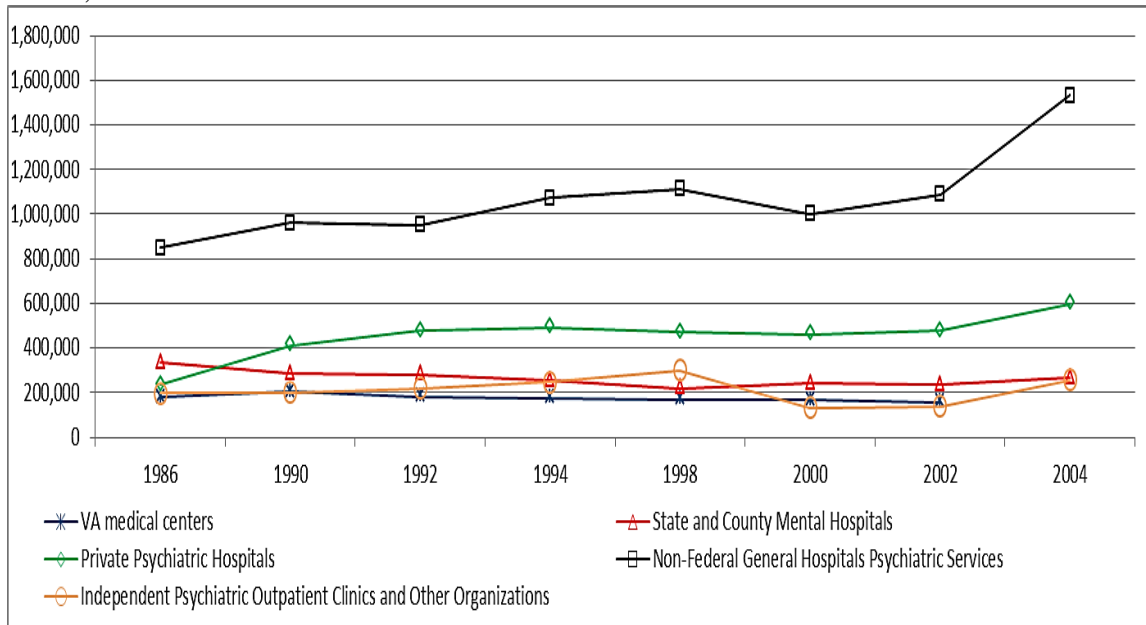
Source. Mental Health, United States 2008

   Although more research is needed into the extent of mental illness in nursing

homes residents, because of the variations within and between states, estimates suggest

around 50 percent of the total population of nursing homes had some type of mental

disorder. The most prevalent disorder among residents in nursing homes is depressive

disorders (SAMHSA 2010). Figure 45 depicts the trajectory of total residents with both

mental disorders and diseases of the nervous system and sense organs. This suggests the

total for both groups increased until 1999 and decreased from 1999 until 2004.

Additionally, mental disorders as primary diagnosis at admission decreased over the 19

year period. However, diseases of the nervous system and sense organs appear to have

followed a different trajectory by increasing the first fifteen years and then a slight

decrease from 1999 to 2004. This figure demonstrates another important trend started in

the community-based care phase and continued in the managed care phase, which is the

nursing home continued to be the principal institution, which provides mental health

treatment to old people with mental illness.

Figure 45.Total Nursing Home residents with Mental Disorder as Primary Diagnosis and
Diseases of the Nervous System and Sense Organ 1985-2004
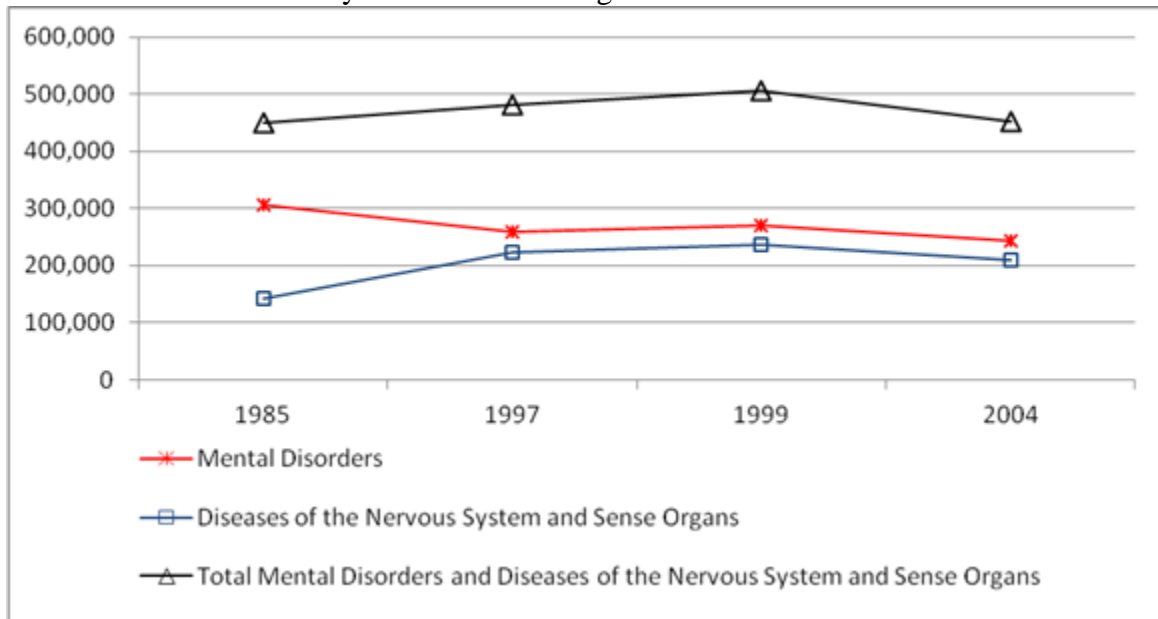
Source. The National Nursing Home Survey 1985, 1997, 1999, and 2004

As in the previous chapter, prisons and jails are an important organizational form

when discussing the mental illness career. However, unlike the previously discussed

organizational forms, use of prisons and jails seems to have increased during this phase.

As deinstitutionalization continued into the managed care phase, studies have reported

higher numbers of inmates in prisons and jails with mental disorders (Torrey et al. 2010).

For example, in 2004, it was estimated that approximately 54 percent of prison inmates,

and in 2002, approximately 64 percent of jail inmates, were thought to have some type of

mental disorder (SAMHSA 2010). Additionally, numerous studies conducted between

1998 and 2006 suggest that between 15 and 20 percent of jail and prison inmates had a

serious mental illness. This can be compared to similar studies from the early 1980s

finding that approximately six percent of individuals had a serious mental illness (Torrey et al. 2010). A report from the Center for Mental Health Services argues that 7 percent of all incarcerated individuals have a serious mental illness; using this conservative estimate would place the rate of serious mental illness three to fours times that of the U.S. population (CMHS 2005).

Torrey et al. (2010) argue jails and prisons have replaced mental hospitals, which is supported by the fact that there are three times more inmates with serious mental illness in jail or prison than in mental hospitals. Consequently, they conclude "We have now returned to the conditions of the 1840s by putting large numbers of mentally ill persons back into jails and prisons" (Torrey et al. 2010: 1). Rikers Island Correctional Facility and the Los Angeles County Jail contend for the dubious honor of the largest mental health hospitals in the U.S. because more individuals with mental disorders reside in jails and prisons than in state and county mental hospitals. These facilities house large numbers of inmates with mental disorders who have committed misdemeanors and do not belong in jails or prisons (CMHS 2005).

Prisons and jails recognizing the different needs of inmates with mental disorders now provide some mental health services. For example, between 18 and 34 percent of prisons in the U.S. maintain some type of rerouting program for inmates with mental disorders. Moreover, 70 percent of state prisons provide some screening during processing, 65 percent conduct psychiatric evaluations, and 71 percent provide some type of counseling (used by about 13 percent of inmates). Seventy-three percent of state prisons provide psychotropic medications that are used by about 10 percent of inmates (SAMHSA 2010). Despite these positive trends, when those with mental disorders are put

into jail or prison, they often do not receive mental health services and may lose eligibility for income support and health insurance when released (CMHS 2005).

From 1993 to 2003 primary care doctors, other general doctors, and nurses were most used for mental health treatments among U.S. adults; this marks the final trend concerning where treatments occur. This is partly explained by the fact that managed care requires use of primary care physicians for referrals to specialty care, increased use of screening devices, and psychotropic medications—all treatments that require less monitoring and are therefore seen as safer. Additionally, the decreasing number of specialty mental health providers has had substantial effects. For example, over 66 percent of primary care physicians' attempts at obtaining outpatient mental health treatments for their patients were thwarted due to lack of mental heath providers, insurance barriers, and lack of, or inadequate insurance coverage (SAMHSA 2010). This runs parallel to the trend in decreasing numbers of outpatient and inpatient care episodes in the specialty mental health sector, and, the increasing use of the non-specialty mental health service sector, which includes primary care and general medicine, community health centers, emergency rooms, nursing homes, and correctional institutions (SAMHSA 2010).

While the structure of treatment experienced radical change in previous phases, the change has been more subtle in this phase. Data indicate a continued emphasis for providing community-based treatments, while decreasing patient numbers and costs associated with inpatient hospital treatment. However, toward the end of this phase, we see indications of decreased patient use from inpatient and outpatient organizational forms. The general trend has included increased use through the 1980s and most of the

1990s followed by decreased use. Despite this trend increased admissions in both inpatient and outpatient organizations occurred, which could have been an adaptive response by institutional actors, or, a consequence of organizational consolidation. Nursing homes also show similar trends, numbers increased until the late 1990s and then decreased, although not as significantly as outpatient and inpatient organizations.

Conversely, two trends that run parallel counter? to decreasing numbers of outpatient and inpatient care episodes in the specialty mental health sector, include the increasing number of inmates with mental illness in jails and prisons and increasing use of the non-specialty mental health service sector. Over the course of the managed care phase, studies suggest prisons and jails have reported higher numbers of inmates with mental disorders (Torrey et al. 2010). This leads some to argue that jails and prisons have replaced inpatient state and county mental hospitals (CMHS 2005; Torrey et al. 2010). Moreover, the increasing use of the non-specialty mental health service sector is partially due to coercive mechanisms used in managed care practices (SAMHSA 2010).

Threshold for Treatment

When examining the treatment career it is important to understand how that career is initiated and what that process looks like. This section focuses on the legal criteria for commitment and discusses commitment proceedings. This process reveals assumptions about mental illness as well as structures used to manage people with mental disorders.

Legal Criterion for Commitment

The community-based care phase demonstrated sweeping changes in the justification for commitment. Justification for commitment changed from need and benefit of treatment, to whether one was dangerous to self or others. Moreover, this

justification for commitment stayed relatively constant over the managed care phase. However, the strict procedural standards for commitment, presented in Lessard v. Schmidt (1972) under the dangerousness standards, were not followed. For example, the majority of state laws have added language that is broad enough to allow judges to commit patients they believe are in need of treatment (Anfang and Appelbaum 2006; Mechanic 2008).

By the end of the 1970s, eight states changed their civil commitment laws that broadened the concept of danger to self and others in order to make involuntary hospitalization a simpler process. These states established that the state's power was unreasonably limited by restricting involuntary commitment to only those who were dangerous. States wanted more authority to help those in need of treatment (i.e., grave disablement), who lacked the ability to seek it. Thus, some states allowed involuntary hospitalization for people whose ability to function in society diminished after being released from mental health treatment (Durham 1996). Some states, "have broadened the definition of "grave disability" for inpatient commitment to include the prospect of severe deterioration, disabling illness, or general inability to care for self" (Anfang and Appelbaum 2006:212). Other states included an "in need of treatment" to their commitment criteria (Morgan, Robins, and Kurzban 2000), while other states and municipalities used administrative procedures to broaden the authority to hospitalize, without changing commitment laws. Moreover, the courts appear more willing to uphold laws that allow broader authority for mental health professionals to commit people (Durham 1996).

The use of the justification for commitment (dangerousness to self or others) as the only criteria did not result in only "dangerous" patients being committed. Research suggests there is little evidence that dangerousness in medical and public records was the mitigating factor that led to commitment (Anfang and Appelbaum 2006; Durham 1996). When evaluating those committed and not committed under the dangerousness to self or others criteria, studies suggest there were no significant differences between those committed before and after the criteria changed (Anfang and Appelbaum 2006). Thus, Anfang and Appelbaum (2006) suggest there was little difference between those committed under the criteria "need for treatment" and the criteria "dangerous to self and others". In fact, instead of threatening or violent acts, the majority of involuntary commitments resulted from annoying or bizarre behavior, poor judgment, and/or a neglect of basic needs (all which tend to co-occur with psychotic disorders). Moreover, the majority of involuntary patients spent only a brief time in the hospitals, and was released back into the community after a few days or weeks (Durham 1996).

There are, however, indications that legal reforms in commitment criteria did change demographic characteristics of voluntary and involuntary patients. For example, before legal reforms there were stark differences between those who were admitted voluntarily and those admitted involuntarily. First, before legal reforms, better-educated female patients were the typical voluntary patient profiles, while old, poor, less-educated males were the typical involuntary patient profiles. After reforms, patient characteristics became more similar. Some argue that this was a result of patients being forced to either accept voluntarily treatment or face involuntary confinement (Durham 1996).

In addition to inpatient commitment, involuntary outpatient commitment was another method of requiring people with mental illness to acquiesce to treatment (Durham 1996). In the 1980s, twenty-five states enacted legislation implementing involuntary outpatient commitment; by the 1990s, twelve were considering similar regulations. By 2005, forty-two states had some form of involuntary outpatient commitment written in law (Mechanic 2008). Typically, these laws were in response to either family member's concerns for relatives who were refusing treatment, or, the concerns of law enforcement agents dealing with individuals with chronic mental disorders who were repeat offenders (Maloy 1996). Sensational cases involving someone with mental illness (Anfang and Appelbaum 2006; Durham 1996; Mechanic 2008) limited resources for inpatient stays and restricted community resources too (Anfang and Appelbaum 2006). Subsequently, over the managed care phase there has been an increased trend toward involuntary outpatient commitments.

However, the managed care phase has seen new issues around the process of civil commitment. Under Medicaid's managed behavioral health care, new issues arose about civil commitment regarding criteria used to assess needs for treatment, how and where treatment occur, and whether the managed care contractor or the mental health authority was responsible for payment when courts ordered treatment (Morgan, Robins, and Kurzban 2000). Because of the increased influence of managed mental health care in both private and public sectors, there has been an effort to contain costs and ration care. In addition to previous changes in legal standards for commitment, economic factors, cost shifting, and availability of inpatient and outpatient services also shapeed commitment patterns (Anfang and Appelbaum 2006).

In a report examining the relationship between how a state's Medicaid managed care contract's language affects civil commitment, Morgan, Robins, and Kurzban (2000) find when a state's contract neglects to define who is fiscally responsible for civil commitment there is a tendency for states to have increased civil commitments. This is because managed care organizations lack incentives to coordinate with the judiciary to find alternative solutions other than inpatient commitment. "Some [Managed Care Organizations] will rely on principles of private insurance law to automatically deny the medical necessity of court-ordered services; others may rely on the Medicaid institution for mental disease (IMD) exclusion to deny payment for court ordered services in State hospitals" (Morgan, Robins, and Kurzban 2000:21). However, collaboration between the managed care organization and the judiciary can reduce the number of civil commitments. For example, cooperation can facilitate judicial awareness of alternative treatments in less restrictive settings than that of an inpatient unit, which can decrease the number of civil commitments (Morgan, Robins, and Kurzban 2000).

Moreover, the report indicates how the structure of a state's Medicaid managed behavioral health care system can shape how treatment is received. For example, "[a] comprehensive system of community based treatment and supports may reduce the need for civil commitment" by providing supportive services that enable individuals to maintain stable functioning within the community (Morgan, Robins, and Kurzban 2000:22). However, it is important to note that states runs their Medicaid managed care systems independently of one another, leading to variation in programs and commitment outcomes. The importance of managed care regulations cannot be underestimated because of the ability to shift or reduce costs of mental health care. Subsequently, these

managed care regulations may inadvertently affect the amount and type of commitments needed and used across different states (Anfang and Appelbaum 2006; Morgan, Robins, and Kurzban 2000).

Commitment Proceedings

As suggested in the previous chapter, legal reforms did not have a substantial long-term impact on civil commitments. However, when legal reforms were first implemented there was an immediate decrease in the number of commitments. Nevertheless, this did not last and commitment rates typically reached or exceeded levels that occurred before reforms took place typically within one to two years (Appelbaum 1994; Durham 1996). An important factor in the reason commitments were never really reduced included political and public need to do something about problems associated with mental illness. For example, because of increasing rates of homelessness, some families' needs for expanded civil commitment authority, and highly visible and sensationalized media cases, state legislators were pressured to broaden civil commitment laws (Durham 1996).

According to Morgan, Robins, and Kurzban (2000) the process for civil commitment tends to be relatively consistent across the country. Most cases start with an initial petition, which is based on an assumption that the individual in question is seen as a danger to self or others, or, is in need of immediate treatment. Founded on this claim, the individual can be placed in an inpatient unit for a short amount of time. This can occur without a court hearing in many states; however, most states limit the amount of time for commitment to 72 hours (although this time limit varies from state to state). At the end of this commitment the individual in question must be released, or, have a court

hearing to determine if she or he meets the criteria for further commitment (Morgan, Robins, and Kurzban 2000).

Involuntary outpatient commitment is used to coerce an individual with a mental disorder into outpatient treatment (Maloy 1996). According to Maloy (1996) these commitments are typically based on less restrictive criteria than inpatient commitments and are seen as a preventative measure. Outpatient commitments were rarely used during commitment proceedings (Maloy 1996; Mechanic 2008) and Maloy (1996) argues that studies done until 1996 showed no evidence in support for this type of commitment as an effective treatment. However, Mechanic (2008) argues this type of commitment is beginning to be used more frequently. One reason for increased use of outpatient commitment is due to managed care programs attempting to avoid and minimize commitments to inpatient facilities when they are fiscally responsible for patients who are committed. Outpatient care also fits with integrating services into the community and is the most fiscally efficient treatment setting. However as indicated above, if the managed care organization is not required to reimburse hospitals for civil commitments to inpatient units, outpatient commitments may not be fully implemented (Morgan, Robins, and Kurzban 2000:21).

The literature suggests the legal criteria for commitment remained relatively consistent requiring some aspect of dangerousness. The concept of dangerousness was broadened, which enabled authorities to commit patients thought to need mental health care; in some ways however, this reverted back to a broader conception of mental illness. An important reason commitments did not decrease included the need of public officials to react to problems related to mental illness. Although the technical understanding of

dangerousness may not have changed, language was added that facilitated easier commitments. Moreover, the process for commitment tends to be relatively consistent across the country and the person in question can be involuntarily committed in an inpatient unit until stabilized, or if not stabilized, have a court hearing to determine his or her need for further treatment.

Regarding commitments, it is important to note the mental health sector's structure and how it affects the length of stay and location when committed. Commitments have not decreased in contemporary times, the length of stay has. With the development and implementation of the community-based care model, length of inpatient stays decreased, typically lasting less than two weeks in general hospitals (Fisher et al 2001). This is because the inpatient organizational form used in commitments changed from state and county mental hospitals to general hospitals. Additionally, the treatment site for committed patients changed to include inpatient and outpatient locations. This appears to be a consequence of managed care organizations' needs to reduce treatment costs. Managed care policies reinforce the community-based care logic because they require providers to reduce costs in various ways, which encourages shorter stays in inpatient settings, shifts costs, and/or diverts cases to outpatient settings if possible. Moreover, managed care cost-shifting activities can unintentionally increase the number of court-ordered inpatient commitments (Morgan, Robins, and Kurzban 2000).

Patient Release

Changes that altered the location of care for the population with mental illness that began in the community-based care phase were reified in the managed care phase. Consequently, the patterns of patient release continued to be contingent on the

organizational form treating or dealing with people with mental disorder. Again, inpatient commitment does not typically last very long compared to commitments during the institutional phase. Release from involuntary commitment generally occurs if the patient's symptoms are alleviated; however, if symptoms are not alleviated, a legal hearing will be held to determine the patient's standing and whether she or he meets the standards for continued commitment. Extended commitments are also time restricted but are longer than the standard observational period (Morgan, Robins, and Kurzban 2000). On the other hand, involuntary outpatient commitments, which tend to be less restrictive than inpatient commitments, are designed as preventative measures and the standards for release are linked to the legal system (Maloy 1996; Mechanic 2008).

The nursing home continues in the role of providing long-term care for old patients with mental disorders; however, mental disorders as primary disorders have decreased over this phase. Similar to the previous stage, the nursing home is a long-term facility and few patients leave for independent living after they have been admitted. Literature suggests that jails and prisons increasingly see more and more individuals with mental disorders. Inmates with mental disorders, are paroled, incarcerated with the general population, or if lucky, are rerouted into programs for those with mental illness; however, only 18 of jails and 34 percent of prisons have rerouting programs.

The Institutional Pillars

During the managed care phase, unlike the other phases, there has been no change in the cultural-cognitive conception of mental illness. Consequently, the biological approach to explaining and treating mental disorder prevails. This cultural-cognitive frame used to understand mental illness plays an important role in determining which

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treatments and locations are desirable and legitimate. However, despite little change in

the cultural-cognitive frame used to understand mental illness, the normative element of

the mental health sector shows evidence of change. First, and in keeping with what began

in the community-based care phase, the disciplinary roles were further demarcated;

psychiatrists neglected counseling as part of their duties and increasingly provided

medical services, especially in the form of psychotropic medications, and psychologists

and social workers increasingly focused on therapy and social supports. Nevertheless, the

use of counseling and therapy in mental health treatments has decreased whereas use of

psychotropic medications has increased (Mechanic 2008).

Next, and associated with the further delineation of disciplinary roles, has been a

change in the location of treatment from the specialty mental health sector and the

increasing use of the non-specialty mental health service sector. Taken together, these

trends suggest that the institutional logic of the managed care phase is the same as the

community-based care phase. The institutional logic demonstrates the interaction of the

cultural-cognitive and normative elements, which, in this case, pushed treatment into the

community; however, what is different about the managed care phase is that treatment is

occurring with more frequency in the non-specialty mental health service sector.

Moreover, with care being pushed into the community, and length of inpatient stays

decreasing, those with severe and chronic conditions are being transinstitutionalized into

nursing homes, jails, and prisons.

This change is a change in the governance structure and is much more subtle than

the change in the logics of institutional care to the community-based care. These changes

are just as profound because coercive forces changed the location of treatment, pushing

treatment further outside of the specialty mental health sector. Managed care's coercive

forms of isomorphism have shaped the mental health care sector. These coercive

mechanisms influence the provider's treatment plans for patients, thus affecting the

normative element of the institution. Increasingly the evidence suggests that primary

care, general care, and nurses were used to treat mental health problems. Moreover these

coercive forces push normative practices, which emphasize medical treatment

(pharmaceuticals) instead of modifying a person's ability to cope in society through

therapy or counseling along with psychotropic medications.

Conclusion

During the managed care phase of treatment there have been no major changes in

the cultural-cognitive conception of mental illness. The DSMs, after the third edition, all

favor Kraepelinian nosology, which assumes a biological ontology for mental illness.

Despite the fact that there are no changes in the cultural-cognitive conception of mental

illness, treatment patterns did change. In addition to the specialty mental health sector,

the non-specialty mental health sector was used to treat those with mental illness. For the

specialty mental health sector, patients seemed to sort out into different organizational

forms depending on their diagnosis. Patients with psychotic disorders would dominate the

use of inpatient settings; patients with nonpsychotic disorders would dominate outpatient

settings; and patients with brain impairment would be in nursing homes. There seem to

be indications that within the non-specialty mental health sector this pattern was also true.

With nonpsychotic patients seeking non-specialty ambulatory help, those with brain

impairment were going to nursing homes, and the prison system mirroring the specialty

mental health sector, with psychotic patients in acute inpatient care and nonpsychotic

patients in walk-in therapy. Increased use of the non-specialty mental health sector to treat the mentally ill changed.

The literature suggests that commitments did not decrease. This was the result of public officials needing to react to problems related to mental illness. Although the technical understanding of dangerousness may not have changed, language was added to facilitate easier commitments. However, the literature does not indicate commitment proceedings have reverted to past procedures like commitment criteria have, but, the process for commitment tends to be relatively consistent across the country. What the literature on commitments suggests is that commitments have not decreased; however people's lengths of stay have. Treatment sites for committed patients changed to include outpatient locations, which had to with managed care practices' desires to reduce costs in various ways. This encouraged shorter stays in inpatient settings and diverted cases to outpatient settings when possible. Similar to changing the treatment site in commitments, psychotropic medications are the most common form of treatment for adults with mental health problems. Psychotropic medications are used because they are less costly than traditional methods of treatment, such as talk therapy or inpatient settings.

The location of care, as indicated above, also went through changes; however, these changes were not as abrupt as deinstitutionalization in the community-based care phase. Data suggest there is a continued impetus toward community-based care in the specialty mental health sector; nevertheless, toward the end of the phase it seemed to acquiesce. Conversely, there was an increase in the number of jail and prison inmates with mental illness as well as the increased use of the non-specialty mental health service sector, which seem to be at least a partial product of the coercive mechanisms used in

managed care practices. Additionally, the patterns of patient release continued to be contingent on the organizational form treating or dealing with people with mental disorder just as in the community-base care phase.

Finally, using neoinstitutional theory to explain these data, we see that despite the fact that there has been no change in the cultural-cognitive conception, there still appears to be changes in the normative and regulative elements of the mental health sector. However, this change is dissimilar from the previous two phases, which were named and understood in this analysis for the institutional logics guiding them. The managed care phase is referred to as, and guided by, a new governance structure known as managed care. The governance structure changed because of coercive forces imposed by managed care organizations, which then changed the normative element of the mental health sector. Managed care generally continues the institutional logic of the community-based care phase by facilitating treatment within the community, although this treatment in the community is increasingly being provided in the non-specialty mental health sector. Moreover, changes in the regulatory element force changes in the normative element of the institution. Subsequently, this creates a new governance structure, which has had just as significant effects on people with mental illness as changes in institutional logics have.

Chapter 7 Socio-Political-Economic and Historical Contexts, Institutional Change,

Organizational Structure, and the Mental Illness Career

This research has demonstrated how patients' mental illness treatment careers depend on change and/or stability among differing levels of social structure. The literature on mental health policy and treatment patterns emphasizes the dynamic nature of treatment structures. The literature on mental health policy and treatment patterns tends to focus on how changes in treatment are the result of new policies or treatment practices. Moreover, contemporary theories of mental health treatment ignore individuals' environments and their effects on treatment. This dissertation finds dramatic changes in the mental illness careers from the institutional care phase to the managed care phase are the result of large changes in the country's socio-political-economic and historical context. These changes in socio-political-economic and historical context affect the mental health sector and how it is structured. Changes in the environment of the mental health sector lead to changes in organizational form and behavior, which alters how a person experiences their mental illness career.

In this chapter, using neoinstitutional theory, I construct a theoretical framework for understanding how changes in the mental health sector affect patients' mental illness careers. This is done by highlighting mechanisms that encourage change and/or stability at different levels of analysis. First I do this by arguing socio-political-economic and historical context during specific treatment phases is an important environmental factor affecting how institutional elements within the mental health sector are structured. Second, I identify how institutional elements affect change and/or stability in institutional components through isomorphic forces. Third, I identify the consequences that these

mechanisms have on organizational fields and the subsequent forms and behaviors of organizations in the field. Fourth, examining the different organizational forms and behaviors, I identify how organizational forms and behaviors affect mental illness treatment careers over time. Fifth, I draw on opposing theoretical descriptions of mental illness and mental illness treatment by emphasizing the assumptions these theories make about patients' engagement in treatment. Sixth, I discuss the role of one particular theory of the mental illness career and how it fits within the varying levels of analysis to explain the mental health treatment career. Seventh, I provide a summary that explains how various levels of analysis affect patients' mental illness treatment careers over different treatment phases and draw conclusions from this summary.

Since my research illustrates how higher levels of social structure affect individuals' mental illness careers are affected, I identify various levels of analysis. The first level of analysis presented is the socio-political-economic and historical context, which provides precedence for the creation and/or conservation of institutional elements within the nation-state being examined (Figure 46). Socio-political-economic and historical context is an important influence on institutional change and stability because it provides justifications for keeping or changing both cultural and structural arrangements within institutional elements. Previous research has identified the historical context as an important factor shaping institutional structure (Grob 1991a; Scott 1986).

The second level of analysis is the institutional environment (Figure 46). In my study it is the mental health sector, which is a distinct component of the health care institution, consisting of roles, occupations, and organizations oriented towards treating mental disorders. While the overall socio-political-economic and historical context

influences the mental health sector's change and stability, another source of change and stability comes from within the mental health sector. The first factor of the institutional environment includes three institutional elements. These elements include: cultural-cognitive, normative, and regulative and serve as the building blocks of the mental health sector. These elements reflect broader justifications for institutional behavior set by the socio-political-economic and historical context. That is the socio-political-economic and historical context of the nation-state provides the framework that justifies stability, or change, of these institutional elements. Therefore, a change in the socio-political-economic and historical context can transform one or all of the institutional elements. The second factor, isomorphic forces, disseminates changes in these institutional elements to lower levels of analysis. Each institutional element generates its own distinct isomorphic force, which either maintains or modifies these institutional components and organizational fields within the institutional environment (Scott 2008).

The third factor within the institutional environment includes two institutional components. These institutional components are the result of interactions between institutional elements and their isomorphic forces. These components are: institutional logics and governance structures. The first component, institutional logic, symbolizes the interaction of cultural-cognitive belief systems with normative practices in an institution. For example, the cultural-cognitive component entails the conceptualization of mental illness while the normative component entails treatment practices and locations. The institutional logic indicates proper objectives for professionals and organizations and how they should be pursued. The second component, governance structure, consists of normative and regulative elements that implement controls and compel conformity in an

institutional environment (Scott et al. 2000). Along with Institutional elements and isomorphic forces these components work together to shape organizational fields.

The organizational field is the third level of analysis and is comprised of standard (i.e., typical) organizational forms and behaviors (Figure 46). New institutional theory argues that organizational forms and behaviors occur because of a need for conformity within a field as produced by isomorphic forces (DiMaggio and Powell 1983). These isomorphic forces come from both institutional elements and their subsequent amalgamation into institutional components. According to Scott et al. (2000), in general, initial changes in institutional logics lead to small-scale creations of new organizational forms and/or behaviors. Over time, if the organizational field continues to provide feedback changes in institutional elements occur. Figure 46 demonstrates this through a feedback arrow that moves from the organizational field back to these institutional elements. An introduction of new logics and organizational forms and/or behaviors requires time to generate political will for this feedback to affect the governance structure. However, once transformed, the new governance structure enforces the institutional logic that either maintains, or generates the creation of, new organizational forms and behaviors. When organizational forms and behaviors change mental illness treatment careers are subsequently affected.

Figure 46. Structural Elements and Mechanisms of Change and Stability Affecting the Mental Health Sector and the Mental Illness Career
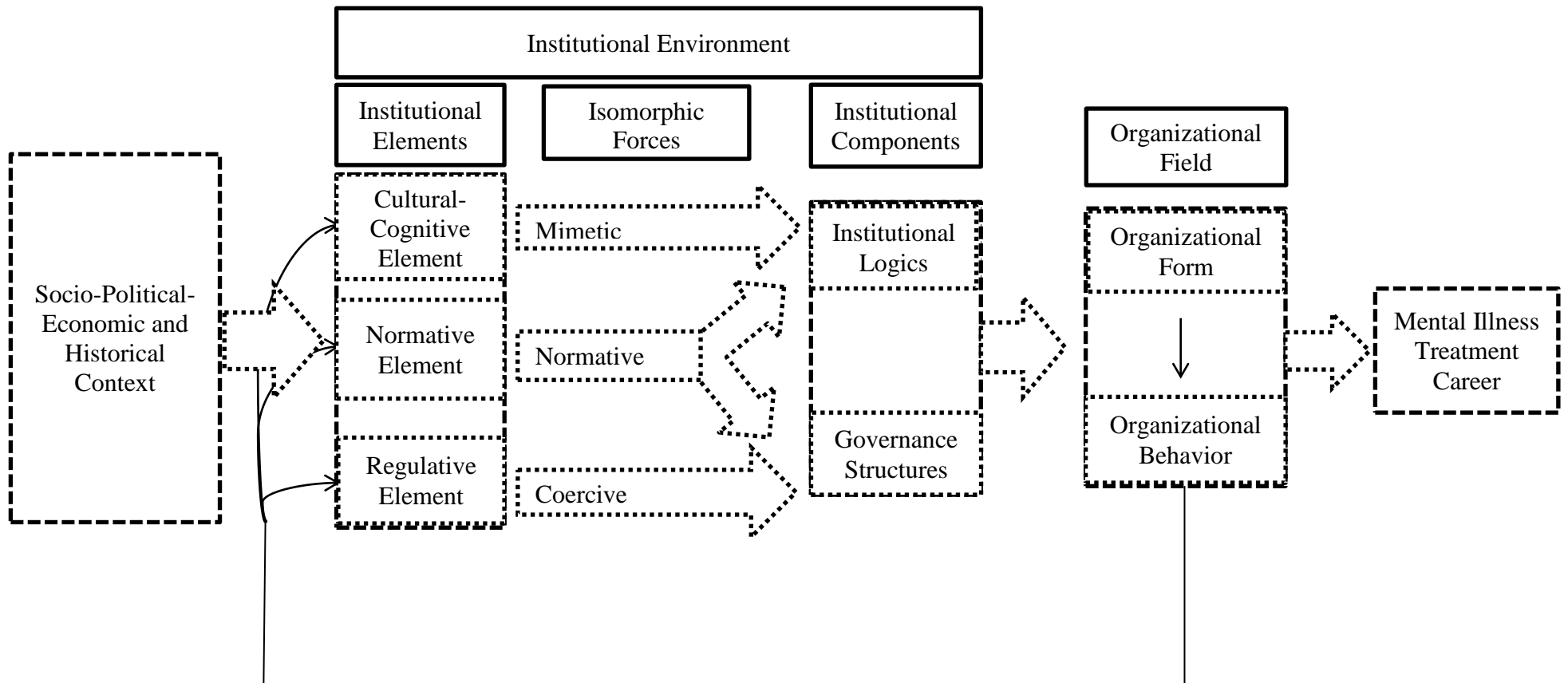
When reviewing previous research on policy and organizational change and theories of mental illness and treatment, both streams of research have remained relatively distinct. Policy and organizational researchers explain structural changes in the mental health sector by arguing that policy implementation and/or new treatment practices in medicine leads to a transformation in the mental health sector. For example, the typical narrative uses the combination of new policies and psychotropic medications to describe how mental health care was revolutionized through deinstitutionalization. In fact, new policies and treatment practices are important. However, my research shows that changes in the socio-political-economic and historical context and changing conceptions of mental disorders (a cultural-cognitive element) are just as important as the effects of policy implementation (a regulatory element) and the development of new medications (a normative element). Thus, any theoretical claims about structural changes in mental health treatment must account for socio-political-economic and historical context and changes in cultural-cognitive conceptions as well as regulative and normative elements of the mental health sector.

Theories have viewed mental illness and treatment as static. Any research theorizing about mental illness and treatment must recognize that conceptions of mental illness as well as treatment structures are malleable. Previous research on patients' mental illness careers has shown the harmful effects of hospitalization (Goffman 1961) and how easily "normal" people can be carelessly admitted to psychiatric hospitals for treatment (Rosenhan 1973). However, it is not at all clear that if replicated, these studies would produce the same results. First, patient characteristics have changed. Specifically, patients with severe and chronic mental disorders are not the exclusive focus of the mental health

sector as they were prior to World War II. Second, the large institutions that Goffman (1961) studied simply do not exist in the same form as they did in the 1950s and 1960s. That is, treatment policies and practices no longer emphasize long-term inpatient treatment. Although state and county mental hospitals endure[10], beginning in the late 1960s, the numbers of patients entering that specific organizational form of treatment decreased substantially (Figure 47) and patients became scattered throughout the mental health treatment sector.

Figure 47. Average Daily Resident and Resident Patient Population at the End of Year 1945-1990
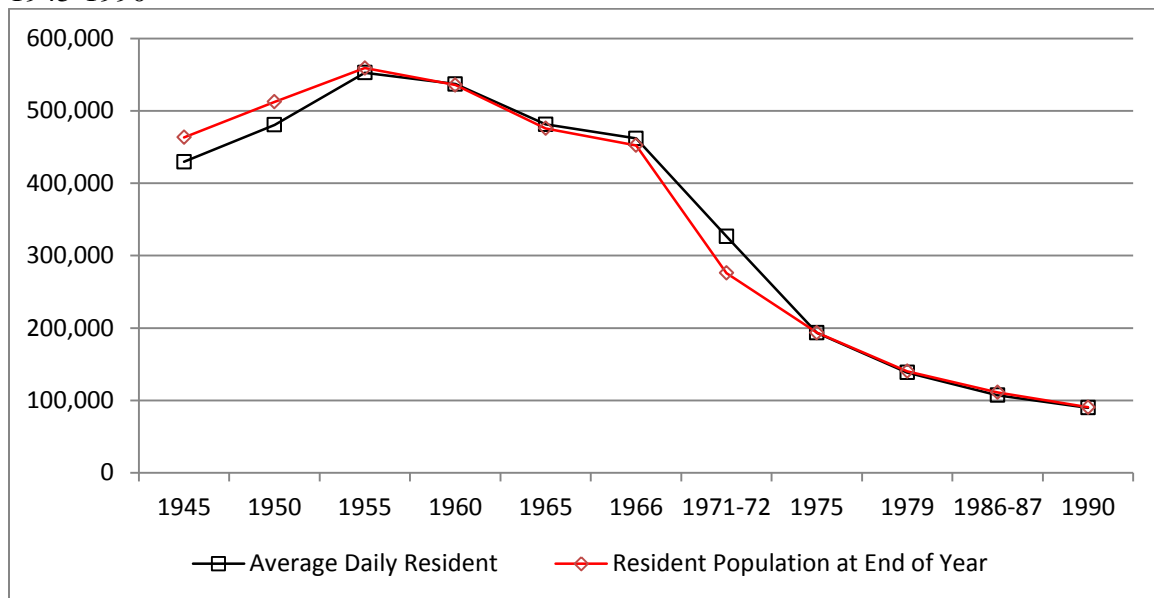
Source. *Patients in Mental Institutions* U.S. Bureau of the Census 1945-1946, *Patients in Mental Institutions* National Institute of Mental Health 1947-1965, U.S. Bureau of the Census and National Institute of Mental Health 1965-1990

Another example, Rosenhan's (1973) study, occurred during the transition from the institutional phase to the community-based care phase. Even though it is still plausible that "normal" persons could fake their way into inpatient or outpatient treatment, it is unclear whether they would be committed against their will, especially since the

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[10] In some states, state mental hospitals have found an organizational niche converting into highbred prison/mental hospitals designed to serve inmates with mental disorders.

participants in his study did not appear to pose a risk to themselves or others. Patients would likely be required to sign themselves into treatment and would not be coerced into treatment. However, a small number of patients may be involuntarily committed even if they did not communicate a credible threat to themselves or others. Nevertheless, because of the structural changes in the mental health care sector, it is likely that length of stay would be dramatically reduced for individuals receiving treatment in contemporary times and expressing symptoms similar to those in the Rosenhan (1973) study.

These are, however, empirical questions that could be addressed in future research. This review stresses the importance of accounting for conceptual and structural changes when attempting to theorize about mental illness and patients' treatment careers. Moreover, treatment is fragmented into numerous organizations and use of coercive treatment structures previously in existence have significantly declined. Each organizational form has different admission policies and practices, which affect how people get into and out of treatment. For example, an inpatient organization must establish a person is credible threat to him or herself or others before involuntarily treating him/her. In addition, an outpatient organization may only involuntarily treat a person at the behest of a court order. Theoretical arguments attempting to explain mental disorders and subsequent treatment careers have generally ignored these changes.

An important question this research addresses is how the mental health care sector went from being structured to bringing relatively few people into a physical location and treating them for long durations to providing more diffuse locations and shorter treatment times. For example, treatment times for some patients lasted several decades during the institutional phase, whereas during the managed care phase treatment times could last as

little as 15 minutes every three months. Closely related to this question, is how the mental health sector transformed its emphasis on people with severe and chronic mental disorders to one focused on personal problems and acute mental disorders. In short, what were the mechanisms that led to such a dramatic transition in the mental health sector? I argue that any theory attempting to explain mental illness treatment careers must, at the very least, take into account that treatment structures change over time and that varying levels of analysis, in which individuals and their careers are nested, have important affects on patients' mental illness careers. Moreover, there has to be a clearer understanding of the reasons behind changes, and mechanisms that transmit that change, rather than simply attributing them to political and professional actors' rational choices.

Socio-Political-Economic and Historical Context and Institutional Effect

An important component in relative change and stability of mental health careers is the socio-political-economic and historical context during specific phases of treatment, which provides justification for keeping or changing institutional arrangements. In this section, I emphasize how the larger socio-political-economic and historical context shapes the mental health sector by providing broad justifications for stasis or change. Grob (1991b) asserted that WWII and the Great Depression had a major impact on the mental health sector. As a result, he argues that conceptual and organizational changes taking place in psychiatry in the years following World War II would have had little impact on how the mental health sector operated if not for these two historical events. Since my study spans a 60-year period beginning immediately after WWII I heed Grob's (1991b) assertion. In fact, these two events did provide a justification in the larger socio-political-economic historical context for broader federal activities. Moreover, these

events legitimated employment of scientists and intellectuals to create and implement policies (Grob 1991a) because the New Deal policies and U.S. involvement in World War II were seen as successful. In addition to this broader socio-political-economic and historical context, psychiatrists came to novel conclusions about how environments affect mental disorders (cultural-cognitive element) and how to treat them (normative element). Without these events engendering a new socio-political-economic and historical context, I argue it is highly unlikely that the institutional logic would have transformed from institutional care to community-based care.

Just as the socio-political-economic and historical context was important to the development of the community-based care logic it was also important to the rearrangement of governance structures that led to the managed care phase. For example, the Great Depression and World War II legitimated federal activities and the employment of experts whereas the community-based care phase began when the country entered a time when institutions (Dalton 2005; Star 1982) and experts (Brint 1994) began to lose public trust. Known as the "Post Fordist" era, this period began in the early 1970s when the country experienced inflation and economic stagnation that could not be relieved by standard Keynesian economic policies (Sewell 2005). Federal activities were delegitimized during that time and resulted in lower levels of support to and from social policies to manage mental illness (Star 1982). Increasing costs in private sector health care and decreased support for public health care led to managed care practices (Scheid 2003). From this socio-political-economic and historical context, social policies reduced support to participants, and, experts' judgments were scrutinized. Post Fordism was a new socio-political-economic and historical context that engendered changes in

normative (i.e., treatment practices and location) and regulative (i.e., managed care practices) institutional elements leading to managed care.

Star (1982) summarizes the policy goals throughout both socio-political-economic and historical contexts created by World War II and Post Fordism. After World War II: "Social policy sought to underwrite the expansion of infrastructure that made possible the new middle-class life in the suburbs. By the mid-1960s the federal government became increasingly concerned with the stubborn problems of those who were left behind, and policy shifted in many areas to explicitly redistributive objectives. And in the 1970s, with persistent stagflation, social policy became increasingly sensitive to cost" (Star 1982; 338). These policy goals were influenced by the socio-political-economic and historical contexts of the day.

The larger socio-political-economic and historical context is an environmental factor that influences the structure and operation of the mental health sector by establishing boundaries about what are and are not legitimate cultural and structural social arrangements. Conversely, socio-political-economic and historical context does not determine the mental health sector's institutional elements. In short, these examples of socio-political-economic and historical context facilitate mental health sector change in a general, not specific, direction. During the time examined, two distinct socio-political-economic and historical contexts (Post Depression and World War II after 1940s and Post Fordism after 1970s) provide parameters for what is, and is not, possible within the cultural, normative, and regulatory institutional elements of the mental health sector.

Institutions and their Influence on the Organizational Field

In addition to socio-political-economic and historical context, another factor that influences stability or change in the mental health career is the institution. In this case the institution is the mental health sector, which consists of institutional elements, the isomorphic forces they produce, and institutional components. Institutional elements produce isomorphic forces that act as mechanisms of change or stability by transmitting larger changes generated by the macro-level socio-political-economic and historical context to other institutional components. In this section, using neoinstitutional theory, I emphasize effects that institutional environments have on organizational fields in the mental health sector. First, I emphasize the role the institution has on organizational forms; second, I focus on how the institution affects organizational behaviors.

Figure 48 shows the dramatic transformation in the type of organizational form used in the mental health sector (from 1955 to 2002). This figure also presents the percentage of the U.S. population engaged in patient care episodes within the specialty mental health sector by type of mental health organization. Additionally, Figure 48 illustrates how the majority of cases were treated in inpatient organizational forms until 1965. These inpatient organizations were typically state and county mental hospitals. However, as I argue in chapter 4, once the cultural-cognitive conception of mental disorders changed to the psychosocial nosology, the definition of mental illness also changed along with what was understood to be effective treatment practices and locations (i.e., the normative institutional element).

Figure 48. Percent of U.S. Population Engaged in Patient Care Episodes within the Specialty Mental Health Sector by Type of Mental Health Organization 1955-2002
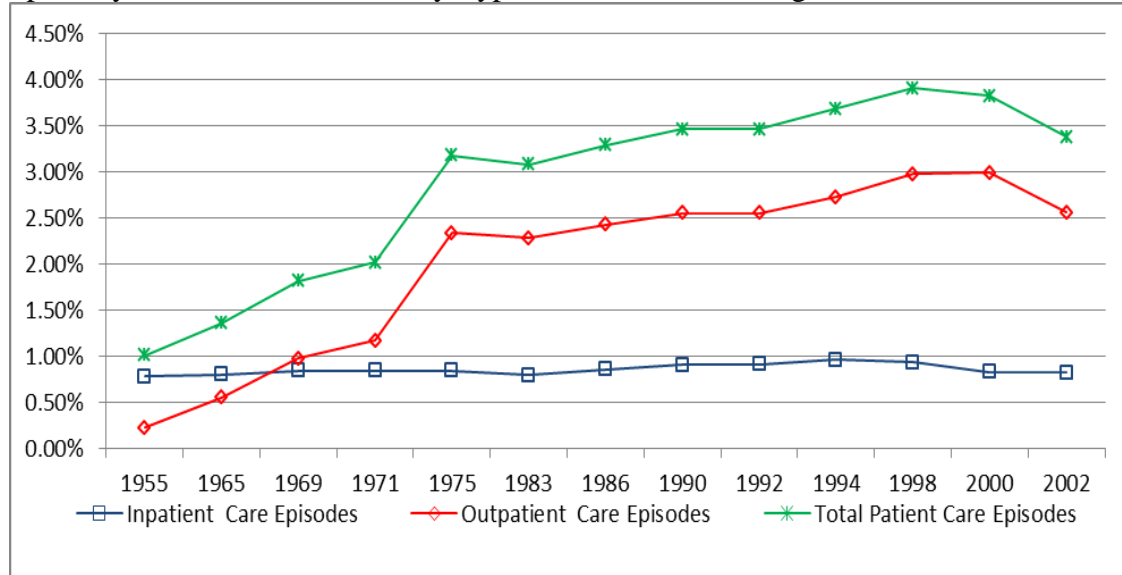
Source. Mental Health, United States 2004 and United States Bureau of the Census, 1955-2005

Taken together, these two elements (cultural-cognitive and normative elements) produced normative and mimetic isomorphic forces, which interacted to form a new institutional logic: the community-based care logic. The community-based care logic called for a new organizational form and behavior within the mental health sector: the outpatient organization. The outpatient organization developed slowly; however, coupled with the new institutional logic, this organizational form led to normative (treatment practices) and coercive (regulatory policies) isomorphic forces that culminated in 1965 with the passage of Medicare and Medicaid (coercive forces). The passage of these policies changed the governance structure having the effect of reifying the institutional logic and implementing immense changes in the organizational field. These changes shifted treatment from predominantly long-term inpatient care in state and county mental hospitals, to short-term inpatient and outpatient organizational forms (Figure 48).

Another change in institutional elements came from a reaction from within organizational fields. Once implemented, the community-based care logic relied mainly on continuum diagnosis and psychotherapy. Derived from the psychosocial conception of mental disorder, continuum diagnosis was problematic because now the boundaries between different disorders were blurred and standard treatments could vary in length of time. Consequently, third-party payers found it difficult to know what disorder they were paying to have treated and uncertainty as to what could be considered a standard length of treatment. As a result, third-party payers began to pressure psychiatrists to recalibrate their nosology (cultural-cognitive) and treatments (normative institutional elements). This feedback points to powerful institutional actors' discomforts with ambiguous conceptualizations of mental disorders and treatment practices that required a change in organizational behavior.

Despite changes in both the cultural-cognitive and normative institutional elements, the community-based care logic has continued. This logic continues because the changes were a synthesis of the psychosocial and Kraepelinian nosologies. Instead of altering the institutional logic, modifications allowed regulative elements adjust. Combined with the normative element (new treatment practices and locations sensitive to costs) the regulative element (policies sensitive to costs) provided isomorphic forces that changed the governance structure. This new governance structure (managed care) encouraged continued use and dependence on outpatient organizational forms (Figure 48). Use of the outpatient organizational form continued until the early 2000s at which point it began to decline; this decline appeared to be the result of managed care practices

forcing treatment out of the specialty mental health sector and into a cheaper alternative (e.g., general practitioners).

In addition to organizational form, the institutional environment also affects organizational behaviors. Figure 49 captures the effects of the mental health sector and its mechanisms on a prominent organization's (i.e., state and county mental hospital) behavior. The first change in the cultural-cognitive conception of mental illness came from inconsistencies revealed during World War II. For example, subtle mental disturbances were viewed as important as severe and chronic mental disorders suggesting mental problems were more common than previously believed. Moreover, environmental stress was perceived to have an important impact on a person's mental status. These inconsistencies led to implementation of the DSM-I in 1952. Figure 49 suggests the implementation of the DSM-I shifted the focus from patients with psychotic disorders to patients with brain impairments. However, brain impairment disorders did not replace psychotic disorders as the most prevalent type of disorder. This nosologic change in 1952 indicates a pattern like the one Kuhn (1964) suggested in his work on scientific revolutions. He argued that long periods of disciplinary agreement were punctuated by periodic disciplinary volatility which led to a scientific revolution. The shift from the Kraepelinian to the psychosocial nosology led to the psychiatric revolution in 1952. Lawrence (2008) argues this shift was the result of institutional actors asserting agency in the form of a grass-roots re-conceptualization of mental disorders.

Figure 49. Estimated Percent of Resident Patients at End of Year in Public Mental Hospitals by Disorder Type 1950 to 2005
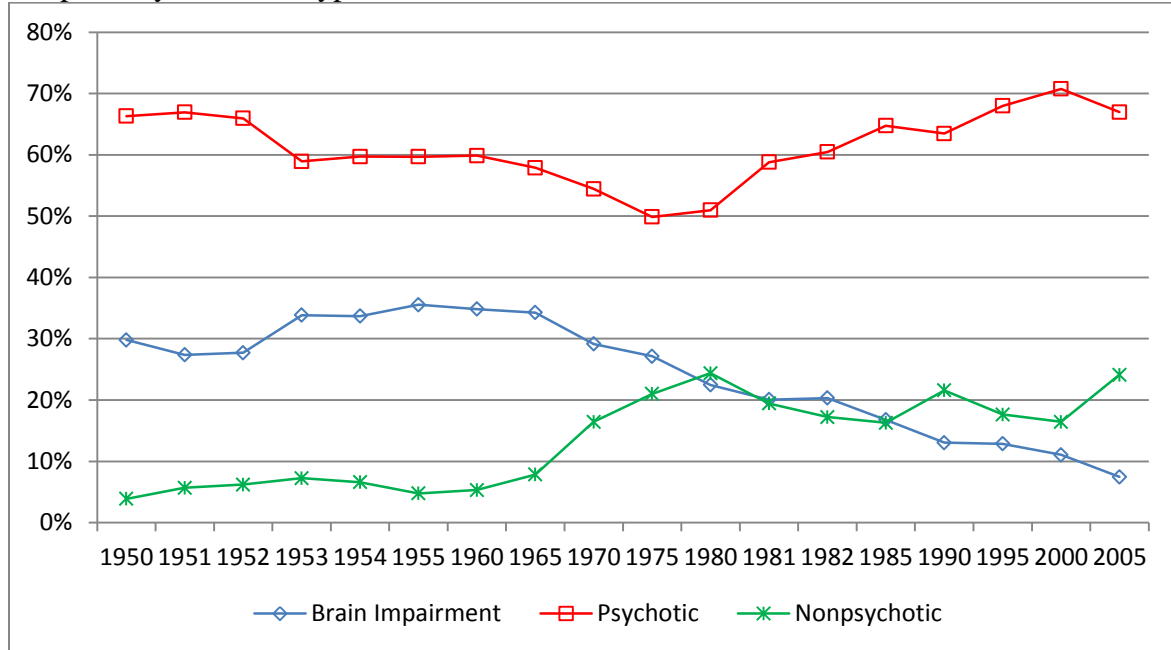
Source: *Patients in Mental Institutions* 1947-1965 and Data from National Institutes for Mental Health 1970-2005

Another important development was the introduction of psychotropic medications in 1954 (Figure 49). Unexpectedly, this new treatment did not appear to have a direct effect on the estimated percent of resident patients (Figure 49). However, this new treatment had an important indirect effect on practitioners and policy makers because it led to the belief that all mental disorders could be treated with medications. As a result, practitioners and policy makers crafted regulatory elements based on this assumption, which led to the creation of Medicare and Medicaid in 1965, and, generated coercive isomorphism that changed organizational behavior. This coercive isomorphism created new regulations that affected who received mental health treatment and where that treatment could occur. At this point there was a decline in the percent of patients with brain impairments and psychotic disorders and an increase in the percent of patients with nonpsychotic disorders in state and county mental hospitals (Figure 49). These trends in

organizational behavior continued until the second change in the cultural-cognitive conception of mental disorders in 1980 with the publication of the DSM-III.

Changes in the cultural-cognitive conception of mental illness were the result of both coercive (third-party payers) and normative (new forms of treatment) isomorphic forces. Third-party payers generated coercive forces by insisting on discrete diagnoses in an attempt to know what disorders they were paying to treat because the introduction of psychotropic medications seemed to confirm the idea that disorders were discrete entities. However, the scientific revolution of the 1970s that led to the DSM-III in 1980 was not akin to what Kuhn (1964) described as a "scientific revolution". Important inconsistencies that led to the paradigmatic crisis during the community-based care phase included psychiatry's decreased legitimacy in mental health treatments within and outside the mental health sector, not disciplinary volatility.

These inconsistencies (i.e., decreased legitimacy) were only resolved when psychiatry reverted back to a description oriented Kraepelinian nosology in 1980. However, the new nosology kept the nonpsychotic disorders that were advocated by the psychosocial model by delineating symptoms into discrete disorders (Horwitz 2002b). Moreover, this problem of legitimacy was not resolved by disciplinary consensus, but by a small number of psychiatric elite who took it upon themselves to solve the crisis at the institutional level (Horwitz 2002b; Kirk and Kutchins 1992; Wilson 1993). The effect of this nosologic change was seen in the rapid increase of psychotic disorders after the implementation of the DSM-III from 1980 to 1981 (Figure 49). Moreover, nonpsychotic disorders began to decrease for the first time in 1980. Brain impairment disorders also

continued to decline beginning with the implementation of Medicare and Medicaid in 1965 and the transfer of a large percent of patients to nursing homes.

Findings emphasize the importance of the mental health sector (institutional environment) on organizational forms and behaviors (Figure 48 and Figure 49). Additionally, findings demonstrate that the DSMs are tools reifying cultural-cognitive understandings of mental disorders in the mental health sector. In the mental health sector, the DSMs are equivalent to technological innovations in other institutions, which shape the way professionals conceptualize the area of institutional focus. However, along with changes in the cultural-cognitive conception, changes in the DSMs were also influenced by normative and regulative institutional elements. These changes affect the degree to which certain classifications of mental disorders receive attention within an organizational setting. Subsequently, the mental health sector and its elements, isomorphic forces, and components affect the organizational field where individuals with symptoms of mental disorders receive treatment. In the next section I focus on how changes in the organizational field affect individuals' mental illness careers.

Organizational Field and the Mental Illness Career

As previously indicated, institutions influence organizational forms and behaviors used within the organizational field. When organizational forms and behaviors change, these changes affect the way individuals engage in treatments for mental disorders. In this section, I attempt to draw the reader's attention to consequences of the organizational field and how changes in the forms and behaviors of organizations within the field affect the way patients with mental disorders engage in treatment.

During the institutional phase (≈1945-1965), the dominant organizational form was inpatient treatment (Figure 48) in state or county mental hospitals where estimates suggest between 60 and 85 percent (Deutsch 1973; Foley et al., 2004) of the inpatient population was treated for mental disorders. Therapies during this phase were composed of various treatments that typically required the individual to be confined and monitored while under treatment (Mechanic 1969). Consequently, the organizational form dominant in this phase depended on controlling its population. From a patient's point of view, treatment was connected to a punitive environment. Generally speaking, people did not actively seek treatment from such organizational forms but were typically forced into treatment.

However, as noted earlier, during the mid-1960s, the structure of treatment changed. Not only did the inpatient organizational form change but the use of outpatient organizations increased due to a series of regulatory acts (e.g., Medicare and Medicaid) that affected the physical location of treatment (i.e., deinstitutionalization). This ended the institutional care phase and began the community-based care phase (≈1965-1985). These regulatory acts transformed the importance of two organizational forms within the mental health sector. For example, inpatient care began to occur more frequently in general hospitals, which began to provide more psychiatric services than state and county mental hospitals. General hospitals were not designed to house patients for very long; they typically stabilized people going through acute crises and released them back into the community. Consequently, treatment was provided in short-term inpatient facilities with an emphasis on medications and proper functioning within the community (Kemp 2007).

Outpatient care organizations, such as independent psychiatric outpatient clinics and federally funded CMHCs, were increasingly important as organizational forms during the community-based care phase from approximately 1965 to 1985 (Figure 48). Outpatient treatment entailed nonresidential or ambulatory care, overseen by psychiatrists (Mental Health, United States, 1985). However, numerous other professional actors in outpatient facilities attempted to prevent or ameliorate mental disorders through a variety of therapeutic services (Grob and Goldman, 2006). As a main component of community-based care, outpatient treatment was designed to keep patients independent and out in the community. During the community-based care phase numerous treatment methods were used in outpatient treatment although individual counseling was favored. During this phase there was a de-emphasis on control over patients in treatment and an initial focus on socially oriented therapies. Patients during this phase began to see treatment as a resource designed to provide help and began self-referring into treatment. While involuntary commitments continued, the structure changed so that patients were not held for treatment as long as had been the case in the institutional care phase.

During the managed care phase (≈1985-2005), the emphasis on providing community-based treatment was left intact; however, the structure continued to change. Structural change has been less dramatic and more subtle than changes during the community-based care phase, although no less significant. While outpatient organizational forms continued to be the dominant location for treatment their use begins to decrease toward the end of my study. This reduction appears to be a consequence of managed care practices that push treatment out of the specialty mental health sector and into the non-specialty mental health sector. Managed care practices tend to reduce

inpatient care and improve access to outpatient mental health services but they alter patients' characteristics from chronic to acute problems (Hutchinson and Foster 2003).

In general, people with chronic mental problems do not benefit from managed care practices to the extent those with acute and personal problems do (Mechanic 2007). For example, outpatient treatment shifts responsibility for seeking treatment onto individuals with mental disorders, which disadvantages those with chronic mental disorders like psychosis and brain impairment. To reduce costs, managed care practices replace psychiatrists with social workers and nurses (Mechanic 2007) in the mental health sector, and general practitioners, outside the mental health sector. Moreover, managed care has changed treatment practices from socially oriented to medically oriented treatments (i.e., group or individual therapy to psychotropic medication) (Scheid 2003). Therefore, during this treatment phase there was a de-emphasis on socially oriented therapies and a shift toward the use of psychotropic medications for all mental disorders. As a result, those with serious forms of mental disorder have a harder time maintaining continuity in their treatment careers. From patients' perspectives treatment is increasingly connected to ambulatory forms of care. During this phase there are instances where commitment initiates treatment; however, inpatient stays are shorter and treatments center on medications more so than in previous phases.

When organizational fields change, forms and behaviors also change; these changes affect the way individuals engage in treatments for mental disorders. For example, when organizational forms change, location and duration of treatments experienced by patients also change. When organizational behaviors change both patient characteristics and treatments considered appropriate change. From the patient's

perspective, when organizational forms and behaviors change organizational policies and procedures that either bring people into or push people out of treatment, are affected. Thus, the reality that organizational forms and behaviors have changed in the last half-century necessitates a change in mental illness careers. In conclusion, when theorizing about mental illness and treatments, it is important to keep in mind that as socio-political-economic and historical context, institutional environments and organizational fields change so too will mental patients' treatment careers.

Theories of Mental Illness and Treatment

In this section, I review theories of mental illness and treatment and compare assumptions made by different theories of mental illness and treatment to the results of my research. In other words, I review how these various theories' predictions compare to actual changes in socio-political-economic and historical contexts, the mental health sector, and the organizational field as well as the effects this has had on mental illness careers over three treatment phases. Reviewing theories of mental illness and treatment shows that all theories make one or more assumption(s) that are problematic when attempting to understand mental illness and the mental illness treatment career. Finally, drawing on empirical evidence from previous chapters, I discuss Aneshensel's (1999) theory of mental illness and how it fits within varying levels of analysis (socio-political-economic and historical context, mental health sector, and organizational field) to explain the mental illness careers over three treatment phases.

Goffman's (1961) analysis examined the place of treatment (the mental hospital), that provided a context for mental illness careers at the time of his research. Goffman (1961) examined two phases (prepatient and inpatient) of the patient treatment career.

There are various problems however, in extending Goffman's (1961) work to explain

how patients with mental disorders engage in treatment. First, Goffman (1961) was only

concerned with whether people were patients rather than whether they had symptoms of a

mental disorder. When analyzing how people entered treatment, Goffman's (1961) work

addressed how the betrayal funnel affected them. His work only concerned those who

engaged in mental health treatment through coerced routes. Second, although

acknowledged by Goffman (1961), it is not clear that all treatment engagements were the

consequence of coercion. Thus, Goffman's (1961) work only applies to a time when

coerced types of treatment were normative.

Finally, Goffman (1961) analyzed a particular type of organization at a particular

time: the asylum. This detail precludes the possibility of other organizational forms

where patients voluntarily seek treatment and how organizational change affects the way

patients engage in treatment (Figure 47). Goffman's (1961) theoretical weaknesses,

therefore, include his assumption that treatment was involuntary and his inability to

acknowledge the potential for differing organizational forms. As a result, Goffman

(1961) would be hard pressed to explain how contemporary patients engage in treatment.

Goffman's (1961) work was a pivotal theory about mental health treatment that made

a major contribution to labeling theories of deviance (Smith 2006). This has contributed to

Scheff's (1999) labeling theory of mental illness. Scheff (1999) developed the labeling

theory of mental illness, which considers psychiatric symptoms as instances of residual rule

breaking. Because Scheff's (1999) theory is so heavily dependent on Goffman's (1961), they

share similar problems. First, Scheff's (1999) theory concerns whether people were

noticeably mentally ill. The assumption of noticeable mental illness neglects those who have

mental and emotional problems that are not visible. Noticeable mental illness limits the theoretical applicability to only those who are visibly mentally ill and receive the residual label of mental illness. This leads me to wonder how a community conceptualizes visible mental illness, and, why his conceptualization of mental illness neglects those not drawing attention to him or herself. Second, like Goffman (1961), Scheff (1999) focused on coerced routes into treatment. This assumed that people were tricked into treatment and would not voluntarily seek treatments. The focus neglected the idea that people could voluntarily seek out solutions for any mental or emotional disorder. Scheff's (1999) theory of mental illness neglected a vast number of individuals with symptoms of mental illness who never interacted with authority figures and never received the residual label of mental illness.

Finally, because Scheff's (1999) theory of mental illness originated in the 1960s and was so heavily dependent on Goffman's (1961) theoretical explanation of treatment, this theory had difficulty explaining how people became mentally ill when the coercive social structure was radically changed (Figure 48 and Figure 49). During the late 1960s and throughout the 1970s, the mental health sector increasingly used voluntary (instead of involuntary) forms of treatment[11] and the percent of people receiving treatment increased dramatically (Figure 48). This finding counters labeling theory's assertion that if people could evade treatment and the mentally illness labeled they would. Moreover, the fact that commitments have remained relatively stable (Appelbaum 1994), suggests Scheff's theory cannot explain why there has been a consistent increase in people seeking treatment since the development of his theory (Figure 48).

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[11] Although commitments remained relatively consistent, the organizational structure changed so radically that increasingly committed individuals would be referred to organizational forms that treated acute episodes and did not have the facilities to keep people for long durations.

Of course, labeling theorists could point to increasing reports (CMHS 2005; Torrey et al. 2010) of people with mental disorders ending up in jail and prison instead of the state and county mental hospitals. It might be argued that jails and prisons serve the same function that the state and county mental hospitals did during the early to mid-20th century. However, what is problematic about this claim is that these two distinct institutions (criminal justice system and the mental health sector) may share similarities but serve different functions. Scheff (1999) argues, during the labeling process, deviants are rewarded for acting mentally ill. Within the criminal justice system, a person's mental status only matters when determining competency to stand trial. Other than determining competency, the criminal justice system has no reason to reward deviants for acting mentally ill. Moreover, there would be no reason or motivation for the deviant to accept the label of mental illness since release would be contingent on sentencing. In fact, people with cognitive and mental disorders are more likely to be victimized in jails and prisons. Finally, the only labeling that matters for people standing trial is whether or not they are labeled guilty or innocent, not ill or well.

The second theory of mental illness is the psychiatric perspective. Unlike the labeling theory of mental illness, the psychiatric or medical model views mental illness as a disease or disorder stemming from discrete medical or psychological events. This conceptualization is different from labeling theory because it does not consider the label or diagnosis of a mental disorder as an important factor in creating mental illness. Gove's (1970) psychiatric perspective is a theory about mental illness; however, this theory, like labeling theory, has implications for the treatment career of the mentally ill. These implications are a consequence of the theory's assumption that mental disorders are similar to physical disorders and occur because of various medical or psychological reasons, not because an

individual receives a label. The first implication is people can enter medical or psychological

treatment either voluntarily or involuntarily. The second implication includes patients being

released from treatment when symptoms are assuaged, however patients may re-enter

treatment if symptoms return. Consequently, people do not necessarily have to capitulate to

their diagnosis and/or treatment, contrary to labeling theory. The third and finally implication

involves various organizational forms being used to treat mental illness. As a result,

treatment is not necessarily involuntary. Subsequently, these implications make the

psychiatric perspective more inclusive in understanding mental disorders and do not limit the

mental illness career to involuntary treatment situations because this perspective does not

view mental disorders as being caused by societal reaction. However, this theory neglects to

account for how changes in social structure affect the conceptualization of mental illness,

which weakens its predictive capabilities.

The second theory explaining mental illness careers is Horwitz's (2002a) *The Social

Control of Mental Illness*, which combines a theoretical explanation of mental illness and

how mental patients engage in treatment. Like Goffman's (1961) and Scheff's (1999)

theories of mental illness and treatment, Horwitz's (2002a) theory of mental illness treatment

suffers a similar problem for the way it conceptualizes mental illness. Although Horwitz

(2002a) acknowledges that the social control approach to mental illness is not intended to

contest the psychiatric perspective, it relies heavily on societal reaction to explain mental

illness. Furthermore, "it is concerned with explaining the reaction of observers to symptoms

of mental illness" (Horwitz 2002a:4). There is no doubt, from the previous chapters, that how

society comes to define a group of symptoms as a mental disorder is profoundly important to

treatment careers, not only to patients but society at large. However, Horwitz's (2002a)

conceptualization of mental illness neglects the role of the individual with mental or emotional problems in seeking treatment. My dissertation suggests society reacts differently to different symptoms of mental disorders—psychotic, nonpsychotic, and brain impairment.

Additionally, the genesis of an individual's mental or emotional problems and how society labels a mental disorder are two distinct events. It is feasible that these distinct events may interact at times, which could lead to some emotional or mental problems, especially in the case of nonpsychotic disorders. However, when it comes to brain impairment and psychotic disorders, it is less clear how societal reactions to individuals create these types of disorders. Any theory of mental health treatment must consider both the genesis of individuals' problems and societal reactions to the problems independently. The genesis of problems is important because the vast majority of contemporary forms of treatment are dependent on whether individuals understand that they have a problem. Societal reaction to mental problems is important because it dictates how individuals with mental disorders are treated.

Next, Horwitz (2002a) argues that changes in social structure affect how people with mental illness engage in treatment. He asserts that involuntary treatments declined while voluntary treatments are increasingly the norm. The organizational forms used for treatments are decentralized and individualistic treatments are provided in less restrictive environments. Individualistic treatments emphasize talk therapy and medication. As previous chapters have documented, social structure has changed over the past 60 years as argued by Horwitz (2002a). However, Horwitz's theory does not show how changes in social structure affect treatments. Consequently, the mechanisms between macro-level changes in social structure and their effects on patients' treatment careers are ambiguous.

Finally, even if mechanisms connecting the macro-level social structure to the micro-level mental illness careers were specified, it is uncertain, based on my research, that these mechanisms would adequately explain changes in mental illness careers. Although legal justifications for commitment, regulatory policies, and treatment practices now provide individuals with more rights and benefits, in support of Horwitz's (2002a) theory, this is not the full picture. Horwitz's (2002a) theory neglects to incorporate how the conceptualization of mental disorders works independently to change the mental health sector as well as interact with the legal justification for commitment, mental health policies, and treatment practices. Together these factors change how individuals engage in treatments.

Consequently, I propose that theories of mental illness and treatment careers should address three issues. Firstly, theories of mental illness should demarcate the difference between the development of mental or emotional problems and society's reactions toward those with emotional or mental problems. Secondly, these theories should recognize that not all people seek treatment, and, those who do are not necessarily coerced into treatment. Thirdly, these theories need to acknowledge that changes in social structure affect conceptions, locations, and methods of treatment, which impact how patients engage in treatments.

Aneshensel's (1999) theory of the mental illness career addresses two of these three issues. First, her theory makes an important distinction between developments of emotional or mental problems, and, when persons are labeled or diagnosed with mental problems. This separates two distinct events conflated by other mental illness and treatment theories. The separation of these two events allows Aneshensel to theorize about individuals who are forced into treatment, voluntarily seek treatment, and/or do not

seek treatment. The importance of emphasizing this theoretical distinction between the development of, and society's reaction toward, mental disorders fits the findings of my research because the mental health sector has varied what is diagnosable over time. Second, as diagnoses have changed, treatment structures have transformed from more coercive to less coercive forms. For example, when the treatment structure was closely related to chronic or serious mental disorders, most treatments were coercive in nature. When diagnoses changed to include nonpsychotic disorders people who would not get caught up in coercive treatments were included. Thus, as diagnoses and treatment structures have changed, people have had to self-select into treatment more frequently. Additionally, Aneshensel's (1999) theory considers how contemporary patients engage in, and end, treatment. Not all people experiencing mental or emotional problems will seek treatment. If people do seek treatments they may not be through coerced or even formal mechanisms. Moreover, how treatment ends can vary.

As a result, Aneshensel's (1999) theory is much more inclusive of different contingencies when explaining mental illness careers. Consequently, her theory does a better job of explaining mental health treatments in contemporary times. However, despite her theory's explanatory qualities, it does not address my third point: it fails to include hypotheses about structural changes in mental health treatments over time. My research demonstrates that how people experience mental illness careers as well as how they engage in treatments are affected by changes in social structures. When organizations treating patients are transformed, patients' treatment careers are also changed.

In summary, it is important to note that the theories I have reviewed have made important contributions to the sociology of mental illness. This review is not just about

what is wrong with these theories, but how a focus, or lack thereof, on differing levels of analysis (i.e., socio-political-economic and historical context, institutional environment, and organizational field) would change what each theory might say about mental illness and mental illness careers. Accounting for theses levels of analyses would allow us to better understand the shape of the mental health treatment sector and anticipate, given the current circumstances, what it will look like in the future. Contemporary theories may explain how patients engage in treatment, but not where they engage in treatment. This is an important factor that sociological theories of mental illness treatment have neglected since Goffman's (1961) work.

Any theory of the mental illness treatment career must account for how patients move into, and out of, treatments. Organizational structures are important to mental illness treatment careers because they affect how patients get into, and out of, treatments. Consequently, mental illness treatment theories must account for specific organizations within different treatment phases as well as the fact that these structures change. For example, during the institutional phase, patients typically entered treatment in large psychiatric hospitals involuntarily. Treatment began and ended at the discretion of a medical professional's judgment as to whether the patient was in need of, or would benefit from, further treatment. During the community-based care phase, as the location for treatment began to change, the way patients engaged in treatments also changed. While involuntary commitments continued to occur in inpatient units, justifications changed from whether patients needed treatments to whether patients were dangerous to self or others. In outpatient units, treatments began and ended on patients' accord or, in collaboration with a practitioner or provider. Finally, during the managed care phase, the

treatment structure continued to change and patients entered and left treatments voluntarily in non-specialty practices and outpatient organizations. However, due to managed care practices, treatments could be denied or ended before either the patient or practitioner was ready. Inpatient treatment could be entered into either involuntarily or voluntarily. Because involuntary treatments could be subject to judicial review, commitments were shorter lived than in previous treatment phases.

Summary

Including various levels of analysis and reciprocal relationships between these levels produces a narrative that explains why and how stability and change within the mental health sector changes the mental illness career during different treatment phases. Understanding why and how stability and change occur allows us to make predictions about the structure of mental health treatment. In this section I emphasize how social structural components change the mental illness treatment career from the institutional care phase to the managed care phase.

Transition from the Institutional Phase to the Community-based Care Phase

The Great Depression and World War II generated profound changes in the mental health sector, within the United States. The Great Depression and World War II were enormous problems that created a socio-political-economic and historical context that required interventions by the federal government to solve (Grob 1991a). Society understood these interventions (i.e., New Deal and military involvement in World War II) as largely successful (Star 1982), and, consequently this new socio-political-economic and historical context allowed for changes in the regulatory institutional element (See arrow A in Figure 50).

In addition to changing the conception about the role of government, World War II directly affected the psychiatric discipline. As a result of psychiatry's role in screening recruits for the war effort, psychiatrists concluded that nonpsychotic disorders were a more serious problem than previously believed (Grob 1991a; Houts 2000; Rains 1966). Psychiatrists in the war began to understand the cause of mental illness as related to environmental stress associated with combat; when caught and treated early, people recovered (Grob 1991). From this socio-political-economic and historical context, new psychiatric conceptions about mental illness and its treatments changed the cultural-cognitive and normative institutional elements (See arrows B and C in Figure 50).

Once the cultural-cognitive conceptualization of mental disorders changed, admission, treatment, and release procedures also changed (See arrow D1 in Figure 50). Through the change in conceptualization of mental illness and new treatment practices and locations, these two elements produced mimetic and normative isomorphic forces, respectively (See arrows D2 and E1 in Figure 50). These isomorphic forces interact to form a new institutional logic: the community-based care logic. The community-based care logic called for new organizational forms and treatments in the community (See arrow F in Figure 50). Acceptance of this new institutional logic and its prescribed organizational forms and behaviors began slowly; however, once legitimized this led to changes in the regulative element (See arrow G in Figure 50).

Passage of Medicare and Medicaid (regulative element) generated coercive isomorphic forces (See arrow H in Figure 50), and, along with normative isomorphic forces (See arrow E2 in Figure 50) reified the institutional logic's new organizational forms by changing the governance structure from the state mental health governance

structure to the federal-state mental health governance structure. This transition to a new

governance structure generated widespread changes within the organizational field (See

arrow I1 and I2 in Figure 50). Commonly known as deinstitutionalization, treatments

were shifted from predominantly inpatient care in state and county mental hospitals to

short-term inpatient hospitals and outpatient organizational forms; this ultimately

changed the way individuals engaged their mental illness treatment careers (See arrow J

in Figure 50). Moreover, the introduction of Medicare and Medicaid increased the power

of third-party payers in the mental health sector.

Figure 50. Factors Affecting Change within the Mental Health Sector during the Institutional Care Phase and Leading to the Community-based Care phase.
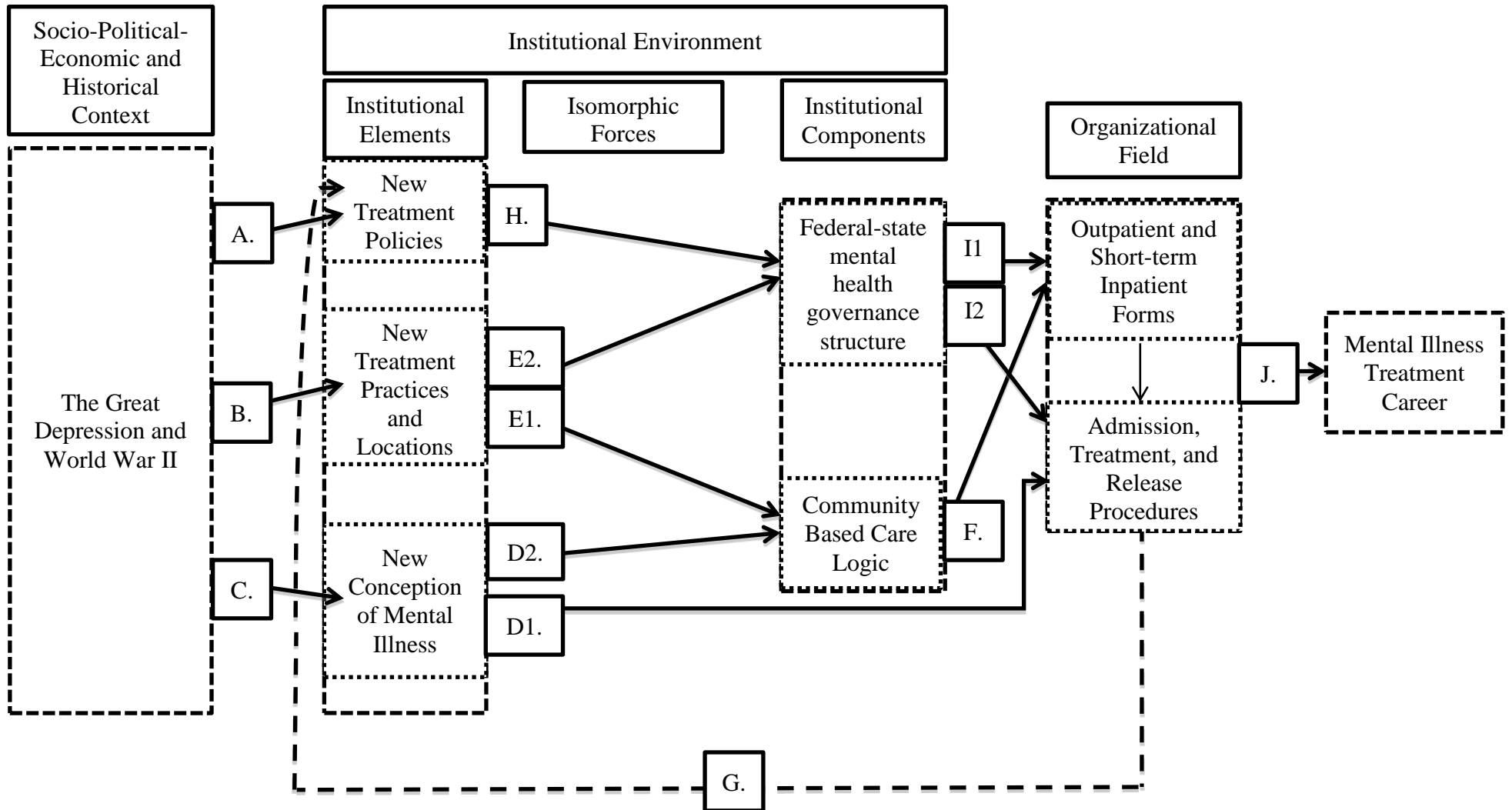
Transition from the Community-based Care Phase to the Managed Care Phase

As a result of deinstitutionalization, the mental health sector went through radical changes and began a new treatment phase: community-based care. The community-based care phase began when the United States was transitioning from the post World War II socio-political-economic and historical context to "Post Fordism," a new socio-political-economic and historical context that delegitimized trust in institutions (Dalton 2005; Star 1982), experts (Brint 1994), and federal interventions (Star 1982) to solve social problems. This new socio-political-economic and historical context allowed for changes in the regulatory institutional element (See arrow A in Figure 51). For example, federal activities were delegitimized, which resulted in lower levels of support to and from social policies to treat mental illness (Star 1982).

Paralleling this socio-political-economic and historical context, forces within the mental health sector began to exert pressure on institutional elements. For example, the conception of mental illness and treatment philosophy was fundamental to the changes that created the community-based care phase. But, the conception of mental illness made it difficult for organizations (i.e., third-party payers) that paid for services to know what disorder was being treated. Additionally, third-party payers questioned standard lengths and types of treatment leaving them uncertain as to what were considered standard lengths and types of treatment. As a consequence of these issues, both federal and private third-party payers pressured psychiatrists to re-conceptualize their understandings and treatments of mental disorders—cultural-cognitive and normative institutional elements, respectively (See Arrow B in Figure 51).

Just as the previous phase, when the cultural-cognitive conception of mental illness changed, this altered admission, treatment, and release procedures (See Arrow C1 in Figure 51). Although there were changes in the cultural-cognitive and normative institutional elements, the community-based care logic continued (see arrows C2 and D1 in Figure 51). This logic continued because changes in the conceptualization of mental illness favored discrete disorders and gave more certainty to third-party payers as to what treatments were being provided, and, their costs. However, combined with the normative element (new treatment practices and locations sensitive to costs), the regulative element (policies sensitive to costs) provided isomorphic forces that changed the governance structure (see arrows D2 and E in Figure 51).

The community-based care logic and new governance structure (managed care) continued to encourage outpatient and short-term inpatient organizational forms (see arrows F1 and G in Figure 51) and behaviors (See arrow F2 in Figure 51). Use of these outpatient organizational forms continued to increase until the early 2000s. However, they then began to decline as a result of managed care practices forcing treatments out of the specialty mental health sector and into cheaper alternatives (e.g., general practitioners). Consequently, who receives treatment, and where one receives treatment, has transformed the mental illness treatment career (seen in arrow H in Figure 51).

Figure 51. Factors Affecting Change within the Mental Health Sector during the Community-based Care Phase and Leading to the Managed Care Phase
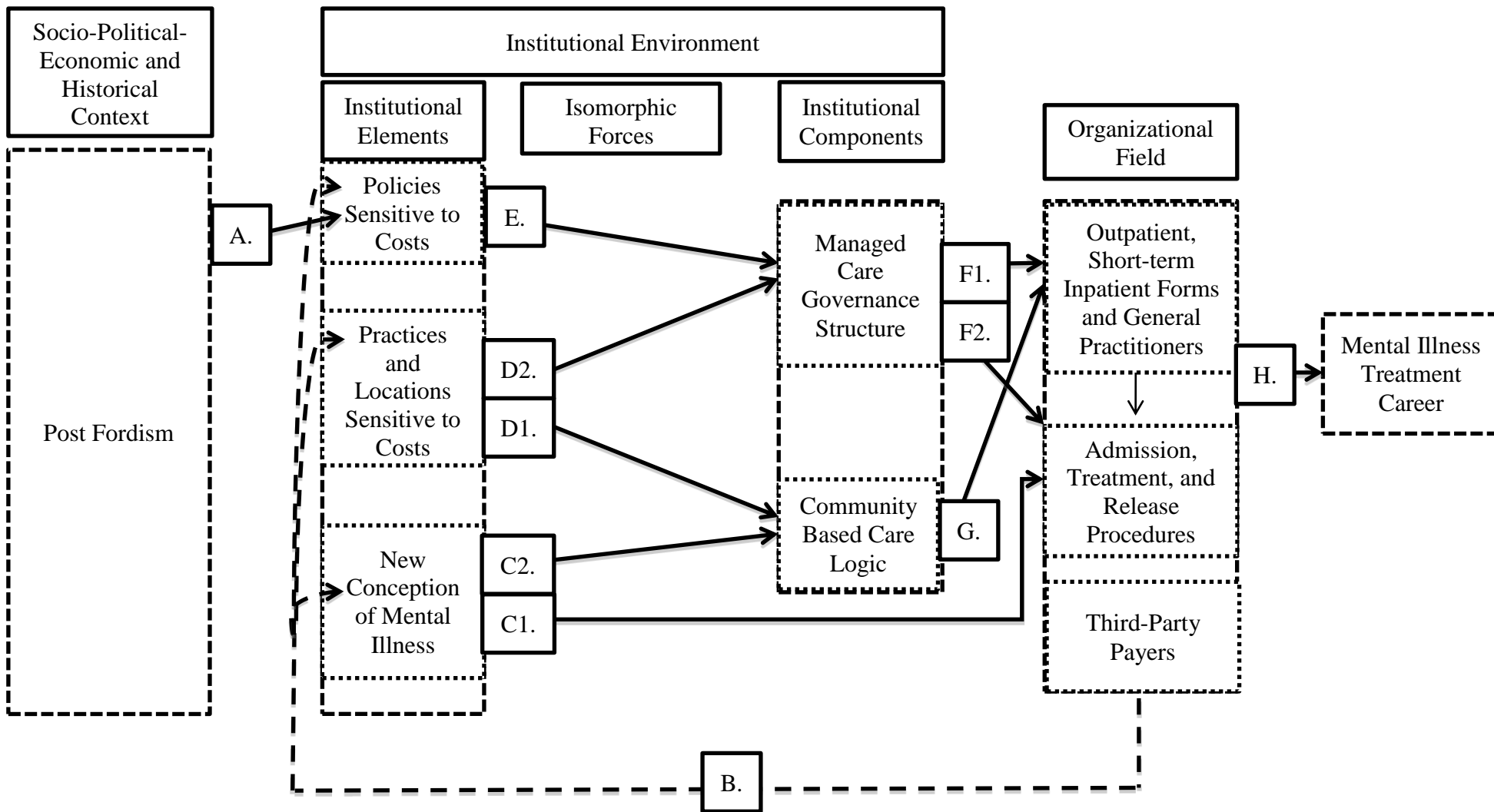
Overall, my research suggests that mental illness treatment careers are contingent on a number of higher levels of social structure. Incorporating various levels of structure allows for a better understanding of what factors are involved in changing the mental illness treatment career. These levels of structure also allow for a better evaluation of previous theories about mental illness and mental illness treatment. Including various levels of social structure as well as their mechanisms of change, has enabled the identification of important theoretical components that other theories have overlooked simply because they did not consider higher levels of analysis and how these levels influence mental illness treatment careers.

Conclusion

In closing, my research suggests that due to the socio-political-economic and historical context generated by "Post Fordism" and the subsequent loss of trust by the public in institutions and experts as well as decreased funding for social policies, there has been no change that alters the predominate institutional logic of the mental health sector[12]. The institutional logic (community-based care) has continued despite cultural-cognitive changes to the conceptualization of mental disorders, and because this logic continues, it does not matter that psychiatry has reverted back to a Kraepelinian conception of mental disorder. This shift back to discrete disorders did not change the institutional focus back to severe and chronic mental disorders because the organizational forms and behaviors remain focused on acute and nonpsychotic disorders. This institutional logic—and the governance structures that reinforce the logic—will continue

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[12] It is unclear at this time whether the passage of the *Patient Protection and Affordable Care Act* in 2010 by President Obama will affect the institutional logics and governance structures involved in the mental health sector; however, with the governance structure and institutional logics left intact by the new health care act it does not appear as though substantive change for those with severe and chronic mental disorder will occur.

until there is a change in the socio-political-economic and historical context that undermines the precedence of this logic[13].

Moreover, the institutional context presented in my research suggests characteristics of mental disorders have just as important implications for what the treatment career will look like as normative treatment practices and coercive regulatory laws and policies. Currently, the mental health sector's structure is designed and implemented to treat patients with short-term acute problems. This is because the mental health sector is designed to treat patients under the psychosocial conceptualization of mental disorders. That is, the mental health sector is designed to treat people with short-term acute problems and by and large force those with long-term chronic problems into this short-term treatment structure. This treatment structure was designed with assumptions created by the psychosocial nosology. These assumptions asserted that, if caught early, symptoms of mental disorder could be alleviated, and, those with symptoms could be restored to "normal" functioning. This has the institutional effect of neglecting the circumstances of people with severe and chronic mental disorders. Although patients with brain impairments and psychosis do receive treatment within the system, the structure and design of the mental health care sector is based on the assumption that people with these severe and chronic conditions will be able to and actively seek treatment when needed.

It is true that patients with brain impairment disorders are more likely to use long-term care facilities, like nursing homes, and patients with psychotic disorders are more likely to use acute inpatient facilities, like non-federal general hospitals. Patients with severe and chronic mental disorders within the contemporary mental health sector are required to

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[13] The recession of 2007-08 could be the potential beginning of a change in the historical context that changes the mental heath sector's institutional logic. However, it does not appear that a new historical context has formed.

actively participate in community-based or outpatient based mental health treatments, however, this is often difficult because of their disorders. In conclusion, my research paints a bleak future for individuals with severe and chronic mental disorders. While treatment continues to be pushed further into the community, patients who would benefit from long-term care arrangements are and will be neglected because contemporary institutional logics and governance structures do not recognize these long term arrangements as valuable.

Limitations

This analysis is dependent on historical analysis. Historical analysis uses primary and secondary sources as data. Unfortunately, the primary sources of data were not collected with this research in mind. Subsequently, it was not possible to accurately track patient characteristics in most of the primary sources. This fact means that the changes in patient characteristics captured in the state and county mental hospitals over time may not replicate in other organizations. Also, the data on the use of nonfederal short-stay hospitals based on the *National Hospital Discharge Survey* and *Utilization of Short-Stay Hospitals* did not list diagnoses in the same manner as *Patients in Mental Institutions*. As a result the categorization of nonpsychotic and psychotic disorders did not precisely match the categorization of nonpsychotic and psychotic disorders created from *Patients in Mental Institutions.* This creates a very loose categorization with some cross classification problems, such as bipolar disorder with schizophrenia. However the trends they present are supportive of previous findings.

Additionally, most of the primary data were from different sources and different times. This resulted in irregular sources of information from which to draw conclusions.

As a result when possible I used secondary sources to fill these gaps. However, it is possible that additional sources could be discovered which could contradict my narrative.

Moreover, this research attempts to incorporate various levels of analysis in a causal explanation regarding how individuals with mental disorders engage in treatment over different treatment phases. This research uses neoinstitutional theory for understanding how institutional elements and actors (Scott 2008) act as mechanisms to transmit changes within the broader historical context. Because this research focused on how larger social structures and the mechanisms they generate affect the mental illness career this research neglected other individual demographic characteristics within the mental health sector (i.e., gender and race/ethnicity differences). Neoinstitutional theory allows for the conceptualization of similarities and changes within particular levels of analysis. However, it does not easily conceptualize people differently and largely ignores groups' different institutional experiences. This is not to say neoinstitutional theory is irrelevant, but only to say it misses how different characteristics, such as race, class, and gender moderate interactions both outside and within institutional settings. Moreover, do different groups have comparable mechanisms such as isomorphic forces which affect group stability and change? Subsequently, future research that can situate demographic differences within a historical context and institutional narrative would greatly expand our knowledge about how institutional change and stability affect groups differently. That is, how do institutional change and/or stability affect people from different racial, class, and gender groups within the mental health sector?

Next, because of data limitations this analysis stops at the mental illness career. However, as Zucker (1991), demonstrates the process of institutionalization occurs within

the cognitive processes of our brains, which also has implications for future research. Research that can situate the roles individuals occupy within the cognitive processes that occur in institutionalization would better connect this process. For example, what does the process of acquiring the psychiatric discipline's cultural-cognitive framework look like? Is this a process that occurs when individuals go through formal training or does this happen before the training begins?

Finally, although the reciprocal relationship between various mechanisms at and between various levels of analysis was acknowledged in this research, it is important to note the predisposition towards a top-down description of the effects of different levels of analysis. This research suggests, and I assert that this is indeed the case; however, I am sure there are situations when lower levels of analysis could and would have just as profound an effect on higher levels of analysis. For example, when do the changing mental health characteristics of a population affect the organizational structure and behavior? When do new mental health organizational types and actions change the institution and its elements? Finally, when do changes in the institutional elements of the mental health sector change the historical contexts? Thus, future research that seeks to determine these specific contexts would also benefit our knowledge about how these reciprocal relationships affect our circumstances.

Future Research

Review of the Involuntary Commitment Laws:

Prior to the late 1960s and early 1970s laws regulating involuntary mental hospitalization were based on the assumption that an individual was in need of and would benefit from treatment. This assumption proved to be malleable and predisposed to

abuses (Gove, Hughes, and Tovo 1985). During the late 1960s and early 1970s there were a number of court cases that affected how and why involuntary commitment should occur. By the end of the 1970s, every state, either had changed its commitment laws or interpreted existing statutes to conform to the idea that people who are a danger to themselves or others are eligible for involuntary commitment (Appelbaum 1994). However, under Medicaid managed care, new issues about civil commitment are present. These issues are related to the criteria used to assess need for treatment, how and where treatment occurs, and whether the managed care contractor or the mental health authority is responsible for payment, when courts order treatment (Morgan, Robins, and Kurzban 2000). Moreover, several states have broadened the definition underlying inpatient commitment to include "grave disability" (Anfang and Appelbaum 2006). The literature in civil commitment is in need of a systematic review of the various laws across the country. This research will conduct a historical/archival analysis of the laws regulating involuntary hospitalization across the fifty states; showing changes in commitment laws from early 1980s until now and how these changes affect the characteristics of persons hospitalized, the treatment they receive, and the rights they retain.

Analyses of the Involuntary Commitment Process:

Prior to the 1970s literature on the commitment process was heavily reliant on empirical methods (Bittner 1967; Goffman 1961; Kutner 1967; Mishler and Waxler 1963; Rosenhan 1973; Scheff 1964; Warren 1977; Wilde 1968). Contemporary research suggests the process for involuntary commitment tends to be relatively consistent across the country. For the majority of cases, they tend to start with an initial petition. Founded on this claim the individual can be placed in an inpatient unit for a short amount of time.

This can occur without a court hearing, in many states; however, most states limit the amount of time for commitment to 72 hours, although this time limit does vary from state to state. At the end of this commitment the individual in question must be released or have a court hearing to determine if they meet the criteria for further commitment (Morgan, Robins, and Kurzban 2000). However, most of the contemporary literature on the commitment process emphasizes how the laws are supposed to work, not the actual process. This oversight in the literature suggests the potential for a number of studies. One possible study would be a participant observation of court proceedings to determine the contemporary process of being civilly committed. Another possible study would be to survey and interview various parties involved in the process of civil commitment, from psychiatric nurses, psychiatrists, defense and prosecutorial attorneys to the judges as well as the people who have been committed. This would enable a better understanding of the procedures that occur within the courts and hospitals when dealing with involuntarily committed people with mental disorders.

Another analysis important to understanding the contemporary affects of the involuntary commitment process is one that looks at changes in mental health treatment over time for both inpatient and outpatient organizations. For example, the laws passed during the 1960s and early 1970s were designed to limit the number of involuntarily committed patients. Appelbaum (1994) suggests the affects of these laws were limited; however, these findings are equivocal. For example, it is not clear if there are more commitments now than when the laws were passed. Moreover, it is unclear as to what types of disorders are more likely to lead to people being involuntarily committed. This would require an examination of data that documents changes in laws, policies, DSM

classifications, patient characteristics, and types of commitment (i.e., voluntary vs.

involuntary).

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Appendix A: Percent of First Admission to State and County Mental Hospitals by

Disorder Type

Brain Impairment		Psychotic		Nonpsychotic		Total Admissions
Year	1945		1945		1945	
General Paresis	5,660	Involutional Psychoses	3,565	Psychoneuroses	2,625	
Other Syphilis	796	Manic-depressive	7,116	Alcoholism	2,510	
With Epidemic Encephalitis	167	Dementia Praecox (schizophrenia)	16,613	Drug Addiction	352	
Other Infectious Disease	211	Paranoia and Paranoid Conditions	1,050	Psychopathic Personality	756	
Alcoholic	3,201	With Psychopathic Personality	770	Primary Behavior Disorders	344	
Drugs	340	With Mental Deficiency	2,323	Other Unclassified, and Unknown	2,337	
Traumatic	365	Other Undiagnosed, and Unknown	2,180	Mental Disorder not Reported	2,734	
Cerebral Arteriosclerosis	13,379					
Other Circulation Problems	628					
Convulsive Disorders	1,425					
Senile	10,435					
Other Metabolic Diseases	806					
New Growth	159					

Orgainc Changes of Nervous System	898					
Epilepsy	377					
Mental Deficiency	1,184					
Personality Disoders due to Encephalitis	120					
Total	40,151		33,617		11,658	85,426

Brain Impairment		Psychotic		Nonpsychotic		Total Admissions
Year	1950		1950		1950	
General Paresis	3,000	Involutional Psychoses	4,863	Psychoneuroses	4,653	
Other Syphilis	454	Manic-depressive	5,240	Alcoholism	7,783	
With Epidemic Encephalitis	114	Dementia Praecox (schizophrenia)	23,637	Drug Addiction	508	
Other Infectious Disease	196	Paranoia and Paranoid Conditions	1,009	Psychopathic Personality	1,551	
Alcoholic	4,485	With Psychopathic Personality	779	Primary Behavior Disorders	723	
Drugs	406	With Mental Deficiency	2,377	Other Unclassified, and Unknown	2,218	
Traumatic	644	Other Undiagnosed, and Unknown	2,555	Mental Disorder not Reported	579	
Cerebral Arteriosclerosis	15,187			No Mental Disorder	374	
Other Circulation Problems	594					
Convulsive Disorders	1,351					
Senile	10,882					
Other Metabolic Diseases	785					
New Growth	221					
Orgainc Changes of Nervous System	1,147					
Epilepsy	510					
Mental Deficiency	1,334					
Personality Disoders due to Encephalitis	64					
Total	41,374		40,460		18,389	100,223

Brain Impairment		Psychotic		Nonpsychotic		Total Admissions
Year	1955		1955		1955	
General Paresis	966	Involutional Psychoses	3,767	Psychophysiologic Autonomic and Visceral Disorders	141	
Other Syphilis	312	Manic-depressive	2,715	Psychoneurotic	5,008	
Alcoholic	4,983	Psychotic Depression	1,051	Personality Disorders	14,293	
Drugs	121	Dementia Praecox (schizophrenia)	22,352	Transient Situational Personality Disturbance	969	
Traumatic	677	Paranoia and Paranoid Conditions	653	Mental Disorder Undiagnosed	3,363	
Cerebral Arteriosclerosis	13,972	Other Undiagnosed, and Unknown	437	Without Mental Disorder	1,525	
Other Circulation Problems	1,269					
Convulsive Disorders	1,641					
Senile	9,589					
Other Metabolic Diseases	520					
All Other Brain Syndromes	2,504					
Mental Deficiency	3,009					
Total	39,563		30,975		25,299	95,837

Brain Impairment		Psychotic		Nonpsychotic		Total Admissions
Year	1960		1960		1960	
General Paresis	526	Involutional Psychoses	4,792	Psychophysiologic Autonomic and Visceral Disorders	178	
Other Syphilis	166	Manic-depressive	2,216	Psychoneurotic	8,483	
Alcoholic	6,530	Psychotic Depresion	1,979	Personality Disorders	20,349	
Drugs	90	Dementia Praecox (schizophrenia)	28,556	Transient Situational Personality Disturbance	2,758	
Cerebral Arteriosclerosis	18,012	Paranoia and Paranoid Conditions	642	Mental Disorder Undiagnosed	4,588	
Other Circulation Problems	1,074	Other Undiagnosed, and Unknown	483	Without Mental Disorder	2,216	
Convulsive Disorders	1,675					
Senile	9,155					
All Other Brain Syndromes	4,176					
Mental Deficiency	3,673					
Total	45,077		38,668		38,572	122,317

Brain Impairment		Psychotic		Nonpsychotic		Total Admissions
Year	1965		1965		1965	
General Paresis	157	Involutional Psychoses	4,110	Psychophysiologic Autonomic and Visceral Disorders	245	
Other Syphilis	61	Manic-depressive	1,398	Psychoneurotic	14,869	
Alcoholic	6,284	Psychotic Depresion	2,746	Personality Disorders	33,662	
Drugs	97	Dementia Praecox (schizophrenia)	23,861	Transient Situational Personality Disturbance	4,957	
Cerebral Arteriosclerosis	15,717	Paranoia and Paranoid Conditions	578	Mental Disorder Undiagnosed	7,544	
Other Circulation Problems	1,240	Other Undiagnosed, and Unknown	278	Without Mental Disorder	1,747	
Convulsive Disorders	1,716					
Senile	5,975					
All Other Brain Syndromes	4,605					
Mental Deficiency	3,629					
Total	39,481		32,971		63,024	135,476

Brain Impairment		Psychotic		Nonpsychotic		Total Admissions
Year	1972		1972		1972	
Organic Brain Syndrom	13,987	Schizophrenia	19,607	Alcoholism	36,788	
Mental Retardation	6,082	Other Undiagnosed, and Unknown	4,573	Drug Addiction	9,093	
				Psychoneurotic	17,406	
				Personality Disorders	14,784	
				All Other	9,365	
Total	20,069		24,180		87,436	131,685

Appendix B: Percent of Resident Patients at End of Year in Public Mental Hospitals by

Disorder Type

Brain Impairment	State	County	Psychotic	State	County	Nonpsychotic	State	County	Total Residents
Year	1950	1950		1950	1950		1950	1950	
General Paresis	14,239	475	Involutional Psychoses	6,744	243	Psychoneuroses	2,741	93	
Other Syphilis	2,208	72	Manic-depressive	18,764	1,274	Alcoholism	2,662	61	
With Epidemic Encephalitis	561	44	Dementia Praecox (schizophrenia)	112,437	5,249	Drug Addiction	187	2	
Other Infectious Disease	297	8	Paranoia and Paranoid Conditions	6,029	545	Psychopathic Personality	1,478	22	
			With Psychopathic Personality	2,053	110	Primary Behavior Disorders	386	26	
Drugs	224	5	With Mental Deficiency	14,768	1,221	Other Unclassified, and Unknown	1,273	68	
Traumatic	1,094	55	Other Undiagnosed, and Unknown	2,792	224	Mental Disorder not Reported	852	43	
Cerebral Arteriosclerosis	17,174	1,240				No Mental Disorder	96	0	
Other Circulation Problems	467	40				Alcoholic	5,279	314	
Convulsive Disorders	5,240	136							
Senile	12,916	1,100							
Other Metabolic Diseases	1,204	55							
New Growth	120	20							

Orgainc Changes of Nervous System	2,780	83							
Epilepsy	1,319	148							
Mental Deficiency	7,838	695							
Personality Disoders due to Encephalitis	118	9							
Total	67,799	4,185		163,587	8,866		14,954	629	260,020
Total State and County	71,984			172,453			15,583		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1955			1955			1955		
General Paresis	18,761		Involutional Psychoses	11,012		Psychphysiologic Disorders	276		
Other Syphilis	2,659		Manic-depressive	25,326		Psychoneuroses	3,897		
			Psychotic Depression	1,078		Personality Disorders	9,950		
Drugs	267		Dementia Praecox (schizophrenia)	196,598		Transient Situational Disorder	690		
Traumatic	2,475		Paranoia and Paranoid Conditions	7,054		Other Unclassified, and Unknown	3,944		
Cerebral Arteriosclerosis	31,860		Other Undiagnosed, and Unknown	3,831		No Mental Disorder	841		
Other Circulation Problems	1,686					Alcoholic	9,003		
Convulsive Disorders	11,328								
Senile	22,305								
Other Metabolic Diseases	1,897								
All Other	8,622								
Mental Deficiency	34,999								
Total	136,859			244,899			28,601		410,359
Total State and County	136,859			244,899			28,601		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1960			1960			1960		
General Paresis	16,303		Involutional Psychoses	13,748		Psychphysiologic Disorders	248		
Other Syphilis	2,077		Manic-depressive	20,055		Psychoneuroses	5,536		
			Psychotic Depression	2,792		Personality Disorders	12,259		
Drugs	320		Dementia Praecox (schizophrenia)	232,311		Transient Situational Disorder	2,137		
Cerebral Arteriosclerosis	39,667		Paranoia and Paranoid Conditions	4,980		Other Unclassified, and Unknown	3,732		
Other Circulation Problems	2,125		Other Undiagnosed, and Unknown	3,094		Mental Disorder not Reported	664		
Convulsive Disorders	12,613					Alcoholic	13,384		
Senile	21,136								
All Other	15,921								
Mental Deficiency	37,641								
Total	147,803			276,980			37,960		462,743
Total State and County	147,803			276,980			37,960		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1965	1965		1965	1965		1965		
General Paresis	11,200		Involutional Psychoses	12,147		Psychphysiologic Disorders	244		
Other Syphilis	1,753		Manic-depressive	16,184		Psychoneuroses	7,449		
			Psychotic Depression	2,954		Personality Disorders	16,225		
Drugs	251		Dementia Praecox (schizophrenia)	224,978		Transient Situational Disorder	3,781		
Cerebral Arteriosclerosis	40,426		Paranoia and Paranoid Conditions	3,389		Other Unclassified, and Unknown	7,130		
Other Circulation Problems	2,518		Other Undiagnosed, and Unknown	2,233		Mental Disorder not Reported	712		
Convulsive Disorders	13,460					Alcoholic	14,365		
Senile	16,055								
All Other	17,153								
Mental Deficiency	37,825								
Total	140,641			261,885			49,906		452,432
Total State and County	140,641			261,885			49,906		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1970	1970		1970	1970		1970		
General Paresis	6,571		Manic-depressive	14,237		Psychphysiologic Disorders	111		
Other Syphilis	557		Psychotic Depression	1,884		Other Neuroses	2,226		
			Dementia Praecox (schizophrenia)	162,970		Personality Disorders	6,581		
Drugs			Other Psychoses	4,665		Alcoholism	9186		
Senile	40,377					Drug Dependence	1952		
All Other	21,079					Transient Situational Disorder	3,182		
Mental Deficiency	30,339					Other Unclassified, and Unknown	3,520		
						Mental Disorder not Reported	13,443		
						Depressive Neurosis	4,119		
						Alcoholic	10,620		
Total	98,923			183,756			54,940		337,619
Total State and County	98,923			183,756			54,940		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1975	1975		1975	1975		1975		
Organic Brain Syndroms	32,975		Dementia Praecox (schizophrenia)	93,244		Alcoholism	12,289		
Mental Deficiency	18,979		Other Psychoses	2,212		Drug Dependence	2,225		
						Depresion	10,544		
						Other Neuroses	1,007		
						Personality Disorders	4,454		
						Other Mental Disorder	1,817		
						Social Malajustments	175		
						UnDiagnosed	7,364		
						No Mental Disorder	327		
Total	51,954			95,456			40,202	3,783	191,395
Total State and County	51,954			95,456			43,985		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1980	1980		1980	1980		1980		
Organic Brain Syndroms	20,784		Dementia Praecox (schizophrenia)	66,594		Alcoholism	6,922		
Mental Deficiency	9,205		Other Psychoses	1,466		Drug Dependence	1,708		
						Depresion	8,282		
						Other Neuroses	449		
						Personality Disorders	3,190		
						Other Mental Disorder	2,140		
						Social Malajustments	388		
						UnDiagnosed	9,240		
						No Mental Disorder	232	pre adult	
Total	29,989			68,060			32,551	2,950	133,550

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1985	1985		1985	1985		1985		
Organic Brain Syndroms	12,484		Dementia Praecox (schizophrenia)	57,269		Alcoholism	4,154		
Mental Deficiency	5,955		Other Psychoses	3,014		Drug Dependence	1,788		
			Affective Disorders	10,892		Anxty/Somato/Dissoc	302		
						Personality Disorders	1,901		
						Other nonpsychotic	4,021		
						Social Malajustments	512		
						UnDiagnosed	4,382		
						No Mental Disorder	836		
								pre adult	
Total	18,439			71,175			17,896	2,429	109,939
Total State and County	18,439			71,175			20,325		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1990	1990		1990	1990		1990		
Organic Brain Syndroms	8,406		Dementia Praecox (schizophrenia)	44,151		Alcoholism	2,412		
Mental Deficiency	3,601		Other Psychoses	4,374		Drug Dependence	1,397		
			Affective Disorders	9,892		Anxty/Somato/Dissoc	294		
						Personality Disorders	1,291		
						Other nonpsychotic	2,627		
						Social Malajustments	308		
						UnDiagnosed	10,570		
						No Mental Disorder	967		
								pre adult	
Total	12,007			58,417			19,866	1,769	92,059
Total State and County	12,007			58,417			21,635		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	1995	1995		1995	1995		1995		
Organic Brain Syndroms	5,560		Dementia Praecox (schizophrenia)	34,999		Alcoholism	1,731		
Mental Deficiency	3,337		Other Psychoses	3,433		Drug Dependence	1,526		
			Affective Disorders	8,600		Anxty/Somato/Dissoc	386		
						Personality Disorders	1,009		
						Other nonpsychotic	2,106		
						Social Malajustments	432		
						UnDiagnosed	4,188		
						No Mental Disorder	830		
Total	8,897			47,032			12,208	1,040	69,177
Total State and County	8,897			47,032			13,248		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	2000	2000		2000	2000		2000		
Organic Brain Syndroms	3,168		Dementia Praecox (schizophrenia)	28,080		Alcoholism	1,198		
Mental Deficiency	2,894		Other Psychoses	3,438		Drug Dependence	1,455		
			Affective Disorders	7,281		Anxty/Somato/Dissoc	462		
						Personality Disorders	1,229		
						Other nonpsychotic	2,425		
						Social Malajustments	277		
						UnDiagnosed	1,312		
						No Mental Disorder	651		
Total	6,062			38,799			9,009	966	54,836
Total State and County	6,062			38,799			9,975		

Brain Impairment	State		Psychotic	State		Nonpsychotic	State		Total Residents
Year	2005	2005		2005	2005		2005		
Organic Brain Syndroms	1,809		Dementia Praecox (schizophrenia)	24,584		Alcoholism	795		
Mental Deficiency	1,915		Other Psychoses	2,681		Drug Dependence	1,732		
			Affective Disorders	6,177		Anxty/Somato/Dissoc	445		
						Personality Disorders	1,114		
						Other nonpsychotic	2,711		
						Social Malajustments	790		
						UnDiagnosed	3,078		
						No Mental Disorder	1,375		
Total	3,724			33,442			12,040		49,206
Total State and County	3,724			33,442			12,040		