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Book Review: Out of Bedlam: The Truth About Deinstitutionalization, by Ann Braden Johnson

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BOOK REVIEWS

OUT OF BEDLAM: THE TRUTH ABOUT DEINSTITUTIONALIZATION.
By Ann Braden Johnson. New York: Basic Books. Pp. xxvi,
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Reviewed by Michael L. Perlin*

I. INTRODUCTION

Jan Costello, a law professor, tells a story about what she experiences whenever she attends a cocktail party and the other guests find out that, before becoming an academic, she worked as a civil rights lawyer representing institutionalized mentally ill individuals:

Weren't you one of those people who got everybody out
of the mental hospital? This is all your fault!¹

She is not alone. I have heard the same charge² — generally leveled with tones of anger, derision and disbelief — so many times that I have begun to routinely turn down social invitations to get-togethers that I can anticipate will take this conversational turn. The promise of crudités and Perrier simply isn't worth it.

I begin this review with this personal confession of antisocial behavior because I think Jan's experiences — and mine, and those of at least a dozen other friends of mine who devoted portions of their careers as litigators to the representation of this most underrepresented and overmaligned subset of "Carolene Products Footnote 4"³ clients — reflect

* Professor of Law, New York Law School. A.B., Rutgers University, J.D., Columbia University Law School. I wish to acknowledge the helpful comments of Joel Dvoskin.

1. J. Costello, *Autonomy and the Homeless Mentally Ill: Rethinking Civil Commitment in the Aftermath of Deinstitutionalization* (paper presented at the Association of American Law Schools' Section on Law & Psychiatry, annual conference in San Francisco, CA, Jan. 7, 1990).

2. Before becoming a law professor, I spent eight years as Director of the New Jersey Department of the Public Advocate's Division of Mental Health Advocacy.

3. In *United States v. Carolene Products Co.*, 304 U.S. 144, 152-53 n.4 (1938), the Supreme Court approved of a more searching constitutional inquiry in cases involving "discrete and insular minorities" traditionally shielded from the political processes. See also, Perlin, *Institutionalization and the Law*, in *PSYCHIATRIC SERVICES*

one of the most troubling (I hesitate to say "maddening") aspects of the discourse that has arisen over the fate of America's homeless individuals: who are they, why did they get that way, what (if anything) can the rest of us do about it, and, most pointedly, who is to blame?

On the latter question, our "ordinary common sense"⁴ is quite clear: the villain responsible for homelessness is deinstitutionalization.⁵ The selection of this particular bogeyman is consistent whether the observer is the lurid *New York Post*, the sober *New York Times*, the flamboyant former NYC Mayor Ed Koch, or scholarly psychiatrists such as E. Fuller Torrey or H. Richard Lamb.⁶ Deinstitutionalization is vilified, variously, as an inherently-flawed social experiment, an operationally-flawed political disaster, or a morally-flawed example of cynical opportunism.⁷ No matter what the diagnosis, though, the cause of blame is virtually universal: blame it on the patients' lawyers.⁸

IN INSTITUTIONAL SETTINGS 75, 77 (Amer. Hosp. Ass'n, ed. 1978) (mental patients are "the voiceless, those persons traditionally isolated from the mainstream of the majoritarian, democratic political system").

4. See Sherwin, *Dialects and Dominance: A Study of Rhetorical Fields in the Law of Confessions*, 136 U. PA. L. REV. 729, 737-38 (1988) ("ordinary common sense" is a prereflective attitude exemplified by the attitude of "[w]hat I know is 'self-evident'; it is what everybody knows"). I discuss the role of "ordinary common sense" (OCS) in the homelessness context in Perlin, *Competency, Deinstitutionalization and Homelessness: A Story of Marginalization*, 28 HOUSTON L. REV. 63, 88-89 (1991).

5. A New York Times national poll conducted just two years ago found that 82% of respondents believed homelessness to be the fault of "mental institutions for releasing patients who aren't able to lead normal lives." N.Y. Times, Jan. 29, 1989, Sec. E, at 5, Col. 1.

6. See e.g., *Cuomo's Curious View of History*, N.Y. Post, Nov. 27, 1989, at 18, col. 1 (editorial); *To Restore New York City: First, Reclaim the Streets; Billions for the Homeless: Snatched*, N.Y. Times, Jan. 1, 1991, Sec. 1, at 28 (editorial); Koch, *Lunacies of Government: Legal, Bureaucratic, Ideological*, N.Y.L.J., July 11, 1988, at 1, Col. 1; Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUN. PSYCHIAT. 899, 902 (1984); E.F. TORREY, *NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL* 156-59 (1988).

7. See Perlin, *supra* note 4, at 86-97 (discussing critiques).

8. See e.g., Lamb, *supra* note 6, at 902; Engel, *D.C.'s Homeless Schizophrenics Get Little Help, Report Finds*, Wash. Post, Apr. 24, 1985, at C1, Col. 2 (quoting Torrey). Former Mayor Koch has characterized libertarian patients' rights lawyers as "crazies." Lambert, *Psychologists Back Koch's Policy on Hospitalizing Homeless People*, N.Y. Times, Sept. 1, 1987, at A1, col. 2. These arguments are spelled out in greatest length in R. ISAAC & V. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* 107-60 (1990).

I respond to Lamb on this and other related issues in D. Mossman & M.

The story goes something like this: nurtured by radical psychiatrists (such as Thomas Szasz and R.D. Laing), spurred on by politically-activist organizations pushing egalitarian social agendas (such as the ACLU), a cadre of brilliant but diabolical patients' rights lawyers dazzled sympathetic and out-of-touch judges with their legal *legerdemain*⁹ — abetted by wooly-headed social theories, inapposite constitutional arguments, some oh-my-god worst-case anecdotes about institutional conditions,¹⁰ and a smattering of "heartwarming successful [deinstitutionalization] cases"¹¹ — as a result of which courts entered orders "emptying out the mental institutions"¹² so that patients could "die

Perlin, *Psychiatry and the Homeless Mentally Ill: A Reply to Dr. Lamb* (unpublished manuscript).

9. See e.g., E.F. TORREY, *supra* note 6, at 156-59 (influence of Freud and Szasz); Lamb, *Involuntary Treatment for the Homeless Mentally Ill*, 4 NOTRE DAME J. L. ETHICS & PUB. POL'Y 269, 276 (1989) (influence of Szasz and R.D. Laing); Haber, *The Freedom To Be Psychotic*, 2 J. L. & HEALTH 157, 165 n. 51 (1987-88) (legal barriers to care erected primarily by the American Civil Liberties Union).

10. In reality, early institutional conditions cases regularly involved shocking disclosures of patient brutality, mistreatment and abuse. See, e.g., *New York State Ass'n for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752, 755-56 (E.D.N.Y. 1973); *Wyatt v. Aderholt*, 503 F. 2d 1305, 1311 n. 6 (5 Cir. 1974).

One [Alabama state hospital patient] . . . died after a garden hose had been inserted into his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth; and a fourth died from a self-administered overdose of drugs which had been inadequately secured.

The chairman of the legal action committee of the National Association of Retarded Children characterized the Pennhurst facility in suburban Philadelphia — the subject of litigation in *Youngberg v. Romeo*, 457 U.S. 307 (1982), and *Pennhurst State School v. Halderman*, 451 U.S. 1 (1981), 465 U.S. 89 (1984) — as "a Dachau, without ovens." L. LIPPMANN & I. GOLDBERG, *THE RIGHTS TO EDUCATION: ANATOMY OF THE PENNSYLVANIA CASE AND ITS IMPLICATION FOR EXCEPTIONAL CHILDREN* 17 (1973).

11. Etzioni, *Deinstitutionalization: A Vastly Oversold Good Idea*, COLUMBIA, Vol. 3, No. 4 (Spring 1978), at 14, 17.

12. The ultimate, causal empirical impact of *O'Connor v. Donaldson*, 422 U.S. 563, 575-76 (1975), in which the Supreme Court found a right to liberty for nondangerous mentally ill individuals who could survive safely in freedom, remains unclear. See 1 M.L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* §2.12,

with their rights on."¹³ When cynical bureaucrats read the judicial handwriting on the hospital walls, they *then* joined the stampede, and the hospitals were thus emptied. Ergo deinstitutionalization. Ergo homelessness. Endgame.

The trouble with this story, of course, is that it's all wrong. Dead wrong. Obscenely wrong. None of this happened this way¹⁴ as even the most superficial review of social history (not to mention legal analysis) should tell us. And yet, we stick to this story because of its convenience, and the way it lets us blame one of our favorite sets of fall guys (fall persons?) for social ills: the civil libertarian lawyers.¹⁵ The popular explanation may be neat, simple and self-contained, but, like most such explanatory packages, it completely misses the point.¹⁶ Our social discourse on this most complicated and difficult question is, simply, built

at 109-10 (1989); Choper, *Consequences of Supreme Court Decisions Upholding Individual Constitutional Rights*, 83 MICH. L. REV. 1, 142-44 (1984).

13. Treffert, *Dying With Their Rights On*, 130 AM. J. PSYCHIATRY 1041 (1973).

14. In reality, patients' rights litigation has been praised for "significantly improv[ing] the quality of life" for institutionalized persons, bringing an end to "[t]he filth, squalor, and unsafe conditions" that had characterized state institutional life. See Ricci v. Callahan, 646 F. Supp. 378, 379 (D. Mass. 1986). Most of the important "first wave" of patients' rights litigation sought the declaration of a right to treatment. See generally, 2 M.L. PERLIN, *supra* note 12, Chapter 4 (discussing cases). While some well-known patients' lawyers have explicitly stated that their goal has been the "abolition of involuntary hospitalization," see B.J. ENNIS, PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS AND THE LAW 232 (1972), other lawyers involved in early test cases focused on the need to fund adequate care and services, see e.g., Wald & Friedman, *The Politics of Mental Health Advocacy in the United States*, 1 INT'L J. L. & PSYCHIATRY 137, 142-48 (1978); Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 407-08 (1982). It also strains the bounds of credulity to attribute the views of one patients' lawyer — albeit one as influential as Ennis — to *all* of the lawyers representing patients and ex-patients.

15. The converse is actually true. The provision of legal services to institutionalized mentally disabled persons is usually shamefully and embarrassingly poor, and has been always been seen as "grossly inadequate" by commentators. See generally, Perlin & Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161 (Summer 1982); 2 M.L. PERLIN, *supra* note 12, Chapter 8; Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in the Trial of Mental Disability Cases*, — LAW & HUMAN BEHAV. — (1991) (in press).

16. See D. BAZELON, QUESTIONING AUTHORITY; JUSTICE AND CRIMINAL LAW 6 (1988) ("As H.L. Mencken once said, for every complex problem in our society, there is a solution that is simple, plausible — and wrong.")

on several series of myths, all of which need to be "unpacked"¹⁷ if we are to bring any measure of coherence to the subject at hand.

The story of homelessness is a complex one; its relationship to deinstitutionalization even more complex. Both phenomena must be viewed in social and political contexts that critically consider a staggeringly-complicated and intertwined set of issues, ranging from the ways that state hospital bureaucracies really work to the different funding mechanisms that control how therapeutic care is provided in different locations (and in facilities run by different governmental units), from the role of psychotropic drugs in the treatment of the seriously mentally ill to the recognition of the universality of irreversible neurological side effects in the populations that have been given these drugs over extended periods of time,¹⁸ and, most importantly, from our morally bankrupt social welfare policies that govern the way that poor people can try to obtain all of life's essentials (housing, entitlements, jobs, general health care) to the callous and mocking cruelty of the Reagan years.¹⁹ The blame-the-patients'-lawyers school of thought deftly and cleverly ignores all of these complicated issues.

All of this may be why I was so overwhelmed when I read Ann Braden Johnson's *Out of Bedlam: The Truth About Deinstitutionalization*,²⁰ the finest piece of extended and thoughtful writing that has yet been done on the deinstitutionalization/homelessness issue.²¹ Dr. Johnson's²² work is a penetrating, thoughtful,

17. I attempt to do this in the insanity defense context in Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE WEST. RES. L. REV. 599 (1989-90).

18. Researchers are beginning to question whether *short-term* drugging can also use similar, irreversible side-effects. See *Riese v. St. Mary's Hosp. & Med. Center*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241, 244-46 (Ct. App. 1987), *appeal dismissed as improvidently granted*, 259 Cal. Rptr. 669, 774 P. 2d 698 (1988).

19. I attempt to contextualize each of these issues in Perlin, *supra* note 4. See generally, 2 M. PERLIN, *supra* note 12, §§7.23-7.27.

20. A.B. JOHNSON, *OUT OF BEDLAM: THE TRUTH ABOUT DEINSTITUTIONALIZATION* (1990).

21. For a superb historical and sociological overview of homelessness, see P.H. ROSSI, *DOWN AND OUT IN AMERICA: THE ORIGINS OF HOMELESSNESS* (1989). For an excellent empirical investigation of the way that the mental health system actually treats the deinstitutionalized, see D.A. LEWIS, S. RIGER, H. ROSENBERG, ET. AL., *WORLDS OF THE MENTALLY ILL: HOW DEINSTITUTIONALIZATION WORKS IN THE CITY* (1991).

22. Ann Braden Johnson, Ph.D., is a clinical social worker currently in charge of providing mental health services for women at the Riker's Island jail in New York City.

comprehensive, balanced and powerful essay on the two social phenomena, the extent of their relationship (and whether there is any meaningful causality in that relationship), the true villains, the true victims, and some possible solutions. The book is near perfect,²³ and should be required reading for everyone who writes about these questions, who votes on legislative bills that deal with these questions, and who provides any kind of treatment, or social or legal services to the populations in question. It's that good.

II. THE BOOK

Deinstitutionalization was a movement at once cynical and idealistic, political and utopian, fiscally conservative and therapeutically daring. It was a great social experiment, and we are still trying to figure out if it worked.²⁴

So begins Dr. Johnson's book. In attempting to explore whether deinstitutionalization "worked," her investigations lead her to a wide variety of social, treatment, fiscal and administrative issues, none of which can be understood by refuge to simple explanations. As she underscores:

The trouble with simplistic thinking about complicated issues is that it is so tempting to look at complex problems as if they were clear and straightforward and easy to solve that we fool ourselves into believing what we really know isn't true. But the truth is so much more horrible that we come to prefer to delude ourselves, hoping meanwhile that someone will come up with answers to all the problems that won't go away.²⁵

She starts by doing what too many authors in this area fail to do: she places deinstitutionalization in its proper historical context²⁶ by

23. See *infra* text accompanying notes 81-92 for my two minor criticisms.

24. A.B. JOHNSON, *supra* note 20, at xiv.

25. *Id.* at 135.

26. For earlier historical investigations of the same question, see A. SCULL, *DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT — A RADICAL VIEW* (1977) [hereinafter *DECARCERATION*]; A. SCULL, *SOCIAL ORDER/MENTAL DISORDER*:

examining the way state hospitals developed,²⁷ and the gradual but constant deterioration of such facilities (until the president of the American Psychiatric Association declared them "bankrupt beyond remedy" in 1958).²⁸ Johnson points out that at about the same time, the state governors — fearing *fiscal* bankruptcy from the spiraling increases in patient populations²⁹ — called for the development of out-patient clinics³⁰ as a means of reducing hospital censuses,³¹ while a federally-funded study commission recommended the creation of community-based treatment facilities to end the isolation of isolated state facilities "where backward, custodial systems still thrive."³²

Eventually, the federal Community Mental Health Center (CMHC) Act of 1963 provided for grants to build community facilities to provide mental health services with special focus on individuals who could not afford fee-for-service mental health care in the community; however, the services that the centers were mandated to provide were, from the outset, Johnson charges, "woefully inadequate for the chronically mentally ill."³³ On the contrary, CMHCs became a treatment setting of choice for the so-called "worried well:" "individuals who had interpersonal and intrapersonal problems [and] were amenable to counseling and psychotherapy."³⁴ All of this happened, of course, years before there was any *litigation* on behalf of the mentally ill,³⁵ it also happened

ANGLO-AMERICAN PSYCHIATRY IN HISTORICAL PERSPECTIVE (1989).

27. A.B. JOHNSON, *supra* note 20, at 5-23.

28. Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIATRY 1 (1958).

29. The number of mentally ill persons under institutional care increased 188 times in the century from 1840 to 1940 during which time the nation's population increased only eight fold. COUNCIL OF STATE GOVERNMENTS, THE MENTAL HEALTH PROGRAMS OF THE FORTY-EIGHT STATES 29 (1950).

30. *Id.* at 40-41.

31. A.B. JOHNSON, *supra* note 20, at 27.

32. *Id.* at 31 (quoting DAVID J. ROTHMAN, CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA, (1980)).

33. *Id.* at 37.

34. E.F. TORREY, *supra* note 6, at 145.

35. On the rise of mental disability litigation as a specialty, see 1 M.L. PERLIN, *supra* note 12, Chapter 1. Although there was a scattering of piecemeal litigation in cases involving the institutionalized mentally disabled, "mental disability law's" birth can logically be traced to 1971 and 1972 — the date of the trial court decisions in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) (right to treatment) and *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (application of procedural due process

entirely independently of the discovery and mass-marketing of the antipsychotic drugs to which the initial exodus of patients from state facilities is usually attributed.³⁶

Johnson carefully traces the expanded development of drug therapy in state hospitals, and the near-euphoria that the availability of such drugs brought on,³⁷ but contrasts the resulting "romance with the efficacy of the medications" with the subsequent "near-universal amnesia about their purpose" (which was, originally, to make patients more amenable to other forms of treatment):³⁸ the drugs became the *sole* treatment available to many state hospital residents, a situation that remains constant to this day.³⁹

In the first wave of right to refuse treatment litigation, state hospital directors were candid that the drugs were the "be all and end all" of public hospital treatment.⁴⁰ We have also since learned that, in many instances, the drugs bring on a set of profound and irreversible neurological conditions — perhaps the most common and pernicious of

to involuntary civil commitment hearings), and the Supreme Court's decision in *Jackson v. Indiana*, 406 U.S. 715 (1972) (application of due process to commitments following incompetency to stand trial determinations).

36. For the standard theology, causally linking the introduction of the major tranquilizers with the reduction of state hospital censuses, see e.g., Brill, *State Hospitals Should Be Kept — For How Long?* in *STATE MENTAL HOSPITALS: PROBLEMS AND POTENTIALS* 151 (J. Talbott, ed. 1980). Compare *DECARCERATION*, *supra* note 26, at 79-89 ("highly implausible" to suggest that drugs' efficacy was "primarily responsible" for early roots of deinstitutionalization); Perlin, *supra* note 4, at 85 nn. 132-33 (citing sources). The causal relationship continues to serve as the orthodox explanation. See Sack, *Crossroads in Mental Health: Red Ink and Unused Wards*, N.Y. Times, Feb. 18, 1991, at A1, Col. 1 ("Since the 1950's, when psychiatry was revolutionized by the introduction of mood-leveling drugs, New York's mental hospitals have been discharging patients into group homes, outpatient programs, and, disturbingly, into the streets").

37. See e.g., A.B. JOHNSON, *supra* note 20, at 46 (quoting JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH 39 (1961) (Arno repr. 1980)): "Unquestionably, the drugs have delivered the greatest blow for patient freedom, in terms of nonrestraint, since Pinel struck off the chains of the lunatics in the Paris asylum 168 years ago."

38. A.B. JOHNSON, *supra* note 20, at 47 (emphasis in original).

39. For a recent opinion decrying the improper use of such drugs as the treatment of choice for virtually all institutionalized mental patients, see *Thomas S. v. Flaherty*, 902 F.2d 250, 252 (4th Cir. 1990), *cert. den.*, 111 S. Ct. 373 (1990) (institutional drugging "substantially departed from acceptable professional standards").

40. See *Rennie v. Klein*, 476 F. Supp. 1294, 1299 (D.N.J. 1979).

which is tardive dyskinesia⁴¹ — that can cause the sort of involuntary and abnormal movements of the tongue, mouth and limbs that forever labels the released patient on the street as one who has been a long-term state hospital resident. As Judge Stanley Brotman observed in the initial trial in *Rennie v. Klein*, the same drugs that are so prescribed to lessen the severity of thought disorders also serve to "inhibit a patient's ability to learn social skills needed to fully recover from psychosis."⁴²

None of this history, however, illuminates the core issue here, an issue that we see starkly every time a suburban zoning panel mobilizes itself to fight against any sort of halfway house or group facility for the once-institutionalized. No one wanted chronically mentally ill patients in their community (the dreaded NIMBY (Not In My BackYard) syndrome).⁴³ And why should we be surprised to learn that property-value conscious suburbanites — even traditional "liberals"⁴⁴ — felt this way, when we learn from Dr. Johnson that community mental health centers — facilities established pursuant to federal law in the early 1960's ostensibly to serve this population⁴⁵ — have exactly the same response.⁴⁶ A Kentucky psychiatrist wrote that state hospitals would have to be maintained because "it would not have been good for a [CMH] center's community image if it were to be seen solely as a place for the

41. See generally, 2 M. L. PERLIN, *supra* note 12, §5.02, at 218-27.

42. *Rennie*, 476 F. Supp. at 1299. See also, Perlin, *supra* note 4, at 103-04 (side effects that retard social skill progress may make patients even less employable once they are deinstitutionalized).

43. See Bach, *Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform*, 98 YALE L.J. 1153, 1160 n. 41 (1989) (discussing NIMBY). Relocation of ex-patients in community settings has been characterized as reflecting "bile barrel politics," the inverse of the politically and socially-desirable "pork barrel" project. See Marmor & Gill, *The Political and Economic Context of Mental Health Care in the United States*, 14 J. HEALTH POL., POL'Y & L. 459, 467 (1989). The term is explained in Pitney, *Bile Barrel Politics: Siting Unwanted Facilities*, 3 J. POL'Y ANALYSIS & MGMT. 446, 448 (1984).

44. See D. ROTHMAN & S. ROTHMAN, *THE WILLOWBROOK WARS* 188-89 (1984) (discussing role of paradigmatically liberal Congresswoman Elizabeth Holtzman in attempting to block the opening of group homes in her Congressional district in Brooklyn); see also, *BAM Historic Dist. Ass'n v. Koch*, 723 F.2d 233, 235 (2d Cir. 1983).

45. A.B. JOHNSON, *supra* note 20, at 37; see generally, E.F. TORREY, *supra* note 6, at 109-50.

46. A.B. JOHNSON, *supra* note 20, at 78-80.

care of former state hospital patients."⁴⁷ To this day, Johnson tells us, clinic workers are compelled to "discourage the chronically mentally ill from continuing" in treatment at CMHCs.⁴⁸

In other words, the patients most in need of follow-up services — those who had been mentally ill and institutionalized for the longest time — were precisely those who were discouraged from seeking treatment at the centers that were originally conceived of as an alternative to the state hospitals. It should also come as no surprise that the treatment available at such centers to the chronically mentally ill was precisely the same drug treatment that had been administered in the large state hospitals from which such persons had been discharged.⁴⁹

The problems become even more muddled when the byzantine question of funding sources gets added to the mix. If all commentators in this area agree on one matter it is this: there is no coherence in the way that the various governmental units allocate funds to be spent on treatment of the mentally ill. Johnson shows graphically the level of our folly here.⁵⁰ She makes one other important point that is all too often lost in

47. *Id.* at 78, citing Farkas, *Aftercare in Community Mental Health Centers*, 21 HOSP. & COMMUN. PSYCHIAT. 304-05 (1970).

48. *Id.* at 78. Support for this conclusion is wide-spread in the literature. See e.g., E.F. TORREY, *supra* note 6, at 142-51; Hiday & Scheid-Cook, *The North Carolina Experience With Outpatient Commitment: A Critical Appraisal*, 10 INT'L J.L. & PSYCHIATRY 215, 230-31, (1987); Note, *1988 Amendments to Georgia's Mental health Statutes: The Latest Attempt to Provide A Solution to the Problem of the Chronically Mentally Ill*, 36 EMORY L.J. 1313, 1344 n. 183 (1987); Schwartz & Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 LOY. L.A. L. REV. 1329, 1386-9 (1987).

49. A.B. JOHNSON, *supra* note 20, at 79-80. The "all but universal" use of medication as the primary treatment modality for serious mentally ill persons in community settings is sharply criticized in Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution*, 72 GEO. L.J. 1725, 1727 n. 23 (1984): "Drugs make custody possible without its traditional physical trappings. To house a drugged population, the thick walls, physical barriers, geographical isolation and staff supervision of state mental hospitals are generally unnecessary." *Id.* at 1750 (footnote omitted). The deinstitutionalization literature provides us with some other important, but generally underreported data. Evidence suggests that some deinstitutionalized homeless individuals remain on the streets to avoid regimens of compulsory drugging in *psychiatric hospitals*, Fischer & Breakey, *Homelessness and Mental Health: An Overview*, 14 INT'L J. MENTAL HEALTH 6, 29 (1986), but other data shows that the deinstitutionalized will seek out medical care in *general hospitals*, see Silver, *Voluntary Admission to New York City Hospitals: The Rights of the Mentally Ill Homeless*, 19 COLUM. HUM. RTS. L. REV. 399, 400-01 n. 3, 402-03 n. 5 (1988); see generally, Perlin, *supra* note 4, at 104-05.

50. A.B. JOHNSON, *supra* note 20, at 93-95.

this policy debate: Medicaid, "the most important federally sponsored program affecting deinstitutionalization,"⁵¹ must shoulder a major portion of the blame for the failure of the states to develop meaningful community-based alternatives to state hospitals because it failed to provide reimbursement for precisely those mental health services that chronically mentally ill patients need following years of hospitalization — "clinical services such as day hospitalization, and nonmedical services such as casework, advocacy, and vocational counseling."⁵² On the other hand, Medicaid made it both convenient and profitable for nursing homes to fill the institutional void.⁵³

The financial *coup de grace* was added here by the expansion of the fully federally-funded SSI program,⁵⁴ which for a variety of administrative and operational reasons made it easier for state mental health bureaucracies to tout deinstitutionalization as an important cost savings measure.⁵⁵ SSI became one of the artificial props that supported

51. *Id.* at 94, quoting U.S. General Accounting Office, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: THE GOVERNMENT NEEDS TO DO MORE 81 (1977).

52. *Id.* at 94.

53. [S]tate officials quickly learned that while Medicaid would reimburse them for 50 percent of nursing home expenses, it would pay nothing toward the care of patients under sixty-five in mental hospitals. The 50 percent reimbursement was available for patients over sixty-five in either location, *but* in the case of hospitalized elderly, the money went into the state's general fund, not back to the mental health system. The federal government was saying, in effect, that it would help states support the senile elderly as long as they were not in state mental hospitals, which were still the states' sole political and fiscal responsibility. . . . A state's mental health department would have had to be stupid not to climb aboard this particular gravy train.

Id. at 94-95 (emphasis in original)(footnote omitted).

54. The Social Security Amendments of 1972, Pub. L. No. 92-603, (codified in 42 U.S.C. §405 (1990)) went into effect on January 1, 1974.

55. A.B. JOHNSON, *supra* note 20, at 88. As Dr. Johnson explains, all players in the system — patient-advocates, therapists, bureaucrats and state fiscal officers — were able to rally around the SSI program as a "no lose" vehicle by which patients could be released from institutions and be assured that there would be funds available to pay for

patient releases in the early 1970's; when the Reagan Administration — in perhaps its single meanest and most cynical "cost savings measure" — jettisoned the mentally disabled from the SSI rolls in 1981,⁵⁶ the moral collapse of our social welfare system was all too apparent for those who wished to see. SSI had allowed (encouraged) states to release patients, since the entitlement program ensured a disability-based, federally-funded grant to provide for the ex-patients' support in community settings. When these payments suddenly and dramatically dried up, it should not have been a real surprise to policymakers, behavioralists (or editorial writers), that some former patients would now be without homes. Dr. Johnson explains this process — likening it, accurately in my mind, to a game of three-card monte⁵⁷ — patiently and carefully.⁵⁸

As a result of all of this, we wound up with a non-system in which many patients were "transinstitutionalized"⁵⁹ to nursing homes and other adult board-and-care facilities (mostly, Johnson stresses, in for-profit, unregulated residences),⁶⁰ and the state hospitals — supported by

subsistence-level community-based housing. *Id.* at 97. During the 15 month gap between the legislation's passage and its date of implementation, state hospital populations declined by 10.8 percent; in 1974, the first full year of SSI availability, state hospitals saw a nationwide decrease in population by 13.3 percent, the largest one year decrease in history. *Id.* at 97-98.

56. See A.B. JOHNSON *supra* note 20 at 99; see generally, Perlin, *supra* note 4, at 78; *Bowen v. City of New York*, 476 U.S. 467 (1986).

57. A.B. JOHNSON, *supra* note 20, at 100. Interestingly, in describing the role of the availability of federal funds in this process, E.F. Torrey uses almost the same exact metaphor. See E.F. TORREY, *supra* note 6, at 152 ("mentally ill individuals became pawns in a huge fiscal shell game").

58. The best-known means by which mentally ill people became homeless began in 1981, when the federal government under Ronald Reagan took advantage of an opportunity to cut costs in the Social Security program by throwing as many people off the disability rolls as they could.

See A.B. JOHNSON, *supra* note 20, at 153.

59. *Id.* at 119-22.

60. *Id.* at 120-28. Recent empirical surveys reveal that, apart from psychiatric wards of general hospitals and psychiatric hospitals, nursing homes are the medical settings in which psychotropic drugs are most widely prescribed. De Leo, Stella & Spagnoli, *Prescription of Psychotropic Drugs in Geriatric Institutions*, 4 INT'L J. GERIAT. PSYCHIATRY 11, 14 (1989).

small-town legislators⁶¹ and, in some jurisdictions, powerful public employee unions — continued to receive the biggest percentage of state mental health budgets, even though the caseloads of such facilities had, in some cases, dropped precipitously,⁶² and had, in others, dramatically changed in composition.⁶³ As a result of all of this, as Johnson notes somewhat ruefully, "the hospital' has maintained its position as the centerpiece of the system, the focal point, the hub around which the rest of the system revolves. . . . [N]othing has really changed."⁶⁴

So much for deinstitutionalization. What about homelessness? Again, Johnson traces — expertly, thoughtfully and sensitively — the factors that have gone to cause the increase in homelessness: spiraling unemployment rates among those with the lowest skill levels, lack of affordable housing stock (partially caused by yuppie gentrification and by tax abatement laws), the death of "single room occupancy" residences (much maligned, but generally a preferable address for many ex-patients), an over-all reduction of welfare benefits and entitlements (including, but not limited to, the SSI debacle), and the stark reality that the poor are now dramatically poorer than they were thirty years ago.⁶⁵

61. Large public facilities have long been a primary employer in small, remote, poor communities. A.B. JOHNSON, *supra* note 20, at 128-29. See also, Sack, *supra* note 36, at 26, Col. 6 (discussing threatened closure of Gowanda Psychiatric Center in southwestern New York State); Fortunato, *300 Protest Closing of Handicapped Center*, *The Trentonian*, Feb. 22, 1991, at 3 (discussing threatened closure of Johnstone Training and Rehabilitation Center in Burlington County, New Jersey).

62. See e.g., E.F. TORREY, *supra* note 6, at 155 (between 1955 and 1981, while New York's number of state hospital patients decreased from 94,000 to 24,000, state hospital staff numbers rose from 24,000 to 37,000; between 1969 and 1981, while patient population in the U.S. decreased by 66%, the total hospital expenditures in constant dollars decreased only by 3%).

63. A.B. JOHNSON, *supra* note 20, at 130 (hospitals shifted from long-term custodial care to providing "brief and rapid interventions in acute exacerbations of a chronic condition"). Interestingly, at the same time, as state legislatures, concerned that it was time to "reverse the pendulum," broadened civil commitment statutes that had been tightened in the wake of early decisions such as *Lessard v. Schmidt*, 349 F. Supp. 1049 (E.D. Wis. 1972) (see *supra* note 34)), the number of involuntarily committed patients began to re-increase significantly, including many first-time commitments, resulting once again, in some jurisdictions, in overcrowding of state facilities. See Perlin, *supra* note 4, at 127-29, discussing, *inter alia*, data reported in Durham & LaFond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 401 (1988).

64. A.B. JOHNSON, *supra* note 20, at 131.

65. *Id.* at 135-44. See generally, Perlin, *supra* note 4, at 70-80 (discussing the "myths of homelessness").

We also know, as Johnson stresses, that a high percentage of homeless individuals are single mothers with small children; there are now more children living in New York City's emergency shelter system than there are single individuals over the age of 18; families outnumber single persons by a ratio of over 3 to 2.⁶⁶ Yet, the public wilfully blinds itself to these social and economic realities, and blames homelessness on deinstitutionalization⁶⁷ (which it can then blame on a handful of "radical lawyers"). How neat.⁶⁸

The mentally ill are, of course, among the most vivid and unsettling of the homeless.⁶⁹ Our causality here, though, is fatally misplaced. Like other extremely poor individuals, mentally ill persons without social support systems — without the financial ability to acquire a stable living environment — may logically be more likely candidates for homelessness than individuals with supportive family and community networks. It also should be fairly clear that the reality of *being* homeless can make someone mentally ill.⁷⁰ Neither of these realities provides the causality that deinstitutionalization's foes heuristically impose on the homelessness debate. As Johnson graphically underlines:

66. *Id.* at 145 (citing Manhattan Borough President's Task Force on Housing For Homeless Families, *A Shelter Is Not a Home* 6 (1987)).

67. The Heritage Foundation, on the Reagan Administration's most favored policy "think tanks" has stated flatly that "deinstitutionalization . . . is the major cause of homelessness." COALITION FOR THE HOMELESS, *STEMMING THE TIDE OF DISPLACEMENT: HOUSING POLICIES FOR PREVENTING HOMELESSNESS* 75 (1986).

68. We also, of course, attribute moral blame to the homeless themselves, *see* Perlin, *supra* note 4, at 107-08, assuming that they are inherently "bad, . . . stubborn, . . . weak, or . . . lack[ing in] will power." J. Costello, *supra* note 1, at 2-3 (unpublished manuscript).

69. Concrete and vivid information about a specific problem often overwhelms the abstract data upon which rational choices are made. *See* Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning*, 69 NEB. L. REV. 3, 12-13 (1990). The vividness effect is one of the heuristic reasoning devices that individuals use in attempting to simplify complex information-processing tasks; the application of these devices leads to distorted and systematically erroneous decisions. I consider the impact of this thinking on the homelessness debate in Perlin, *supra* note 4, at 81 n. 113; *see generally*, Saks & Kidd, *Human Information Processing and Adjudication: Trial By Heuristics*, 15 L. & SOC'Y REV. 123 (1980-81).

70. *See* Kaufman, *Homelessness: A Comprehensive Policy Approach*, 17 SOC. SCI. REV. 21, 23 (1984) (data reveals that homelessness results in mental deterioration).

The picture of the homeless person as a solitary, deranged individual, dumped unfeelingly by a state mental hospital on a street corner and told to sink or swim, never quite leaves the public imagination — even though the "dumping" took place twenty years ago and even though we *know* most of the homeless are single-parent families with small children.⁷¹

The problem is exacerbated yet one more time by the great gap (a chasm, really) between what the homeless mentally ill need and what they get. Their needs, as Johnson sees them, are fairly concrete: adequate housing, outreach programs, access to medical services when needed, instruction in the "skills of living," work training, work, "non-condescending treatment" and long-term access to psychiatric and psychological services.⁷² Self-evidently, they do not receive these services.⁷³ On the other hand, there *are* programs that do work, and Johnson tells us about several well-known ones.⁷⁴ The blueprint, in other words, is there for communities and governmental entities to imitate. That we choose not to do so appears inexplicable.

According to Johnson, our fantasy of the homeless has two sources: first, it tidily explains away a messy social problem (with the implicit solution of reinstitutionalization), and second, it conforms to a politically conservative view of social problems as small, local events not in need of massive federal intervention. She adds, ominously, "That both ideas are irresponsible and false is, of course, irrelevant."⁷⁵

So: why do we adhere to "irresponsible" and "false" ideas, and why is our discourse based on such a proliferation of myths? Johnson offers several interpretations in addition to the ones already discussed. Our social and governmental policies are still driven by the Protestant ethic; we draw a sharp line between the "deserving" and the

71. A.B. JOHNSON, *supra* note 20, at 55.

72. *Id.* at 184-91.

73. *See id.* 191-96 (discussing conflicts in currently-existing programs, and blaming poor level of services on internal staff conflicts, funding-driven programming, and priority-setting resulting in staff concerns and needs "always com[ing] first").

74. A.B. JOHNSON, *supra* note 20, at 196-202 (*e.g.*, Fountain House, The Lodge, PACT, the "work ward", day hospital programs, and patient-run self-help programs).

75. *Id.* at 156.

"undeserving" poor,⁷⁶ and, in our line-drawing, the homeless mentally ill come out clearly on the "undeserving" side of the ledger.⁷⁷ Also, historically, we have chosen to "[b]lame the victim" for our social ills:⁷⁸ what better victim than the homeless mentally ill, *especially* when so many more of them appear to be female, poor and members of racial and ethnic minorities?⁷⁹

Here, Johnson casts a significant amount of blame on the big business aspects of the mental health system,⁸⁰ and I think she is right about this analysis. But, for reasons that I will explore in the next section, I think this explanation only partially illuminates the dilemma.

III. CONCLUSION

My quibbles are, to be sure, fairly minor. First, I think Johnson's analysis of the interplay between mental illness and criminal behavior⁸¹ causes her to be too dismissive of the role of responsibility

76. See Perlin, *supra* note 4, at 107-08:

The deinstitutionalized homeless represent the latest group of the "undeserving poor" to feel public and political wrath. As a result of the social myths and meta-myths that have evolved about the mentally ill over centuries, the deinstitutionalized homeless exacerbate that wrath, heightening our feelings of "anger and revulsion" towards them, especially those whom we feel have "given in to their dependency needs."

Id. at 107-08 (footnotes omitted).

77. A.B. JOHNSON, *supra* note 20, at 221-22.

78. *Id.* at 229. See also, Perlin, *supra* note 4, at 110 ("Our official policies -- 'harsh in execution' — blame the deinstitutionalized homeless for their plight and thus legitimate political bias toward this population"), quoting Fischer & Breakey, *supra* note 48, at 27; see also, Kaufman, "Crazy" Until Proven Innocent: Civil Commitment of the Mentally Ill Homeless, 19 COLUM. HUM. RTS. L. REV. 333, 363 (1988); Goldman & Morrissey, *The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform*, 75 AM. J. PUB. HEALTH 727, 729 (1985).

79. Perlin, *supra* note 4, at 79-80.

80. A.B. JOHNSON, *supra* note 20, at 209-11.

81. See *id.* at 158-76. According to Johnson:
 mental illness should not be used as an excuse,
 a means to escape responsibility for one's
 actions, a defense likely to keep one out of jail if

and trial competency in the criminal justice system. These issues (which are actually peripheral to the focus of her book) are far more complicated than the unsuspecting reader might infer from her treatment.⁸²

Second, and more important, as good as Dr. Johnson's book is, and as persuasive as I found it on its merits, I found myself wishing that she had sealed its one gap, to have thus perfectly completed her argument. She neglects to directly confront the most intractable question of all: *Why* do we feel the way that we do about these people?⁸³ While she argues persuasively that we remain in thrall of the mentally ill because we conflate their behavior with dangerousness (and her references to garish tabloid headlines prove her point wonderfully),⁸⁴ she still does not do justice to this final (seemingly unanswerable) question: what is it about the mentally ill that causes the rest of us to act irrationally, both on a personal, emotional level, and on a political, systemic level? Why do we rely (almost exclusively) on flawed cognitive psychology devices⁸⁵ to shape our views of this population?

This is an extraordinarily complicated matter. My tentative answer is that our attitudes are shaped by two social forces: *social classism* (the deinstitutionalized homeless being "jobless, penniless, functionless and supportless"),⁸⁶ and *sanism* (the "irrational thinking,

that's where anyone else caught committing the same crime would go. It's *fair* for mentally ill offenders to go to jail, and for some of them it may be the best possible place to be.

Id. at 175 (emphasis in original).

82. My criticism is not merely that I disagree with Johnson. I do, *see* Perlin, *supra* note 17; Perlin, *supra* note 66, but that is not my point. My concern is that the brevity with which she treats two enormously important philosophical, constitutional and moral questions — can we hold criminally liable one who may not be responsible for her acts? can we put on trial someone who may not understand the charges brought against her nor be able to consult with her lawyer? — may lull the reader into thinking that these are not particularly important questions. They may not be for the resolution of the deinstitutionalization/homelessness debate, but they remain important to society for many other instrumental and normative reasons. For a more in-depth discussion of these issues, *see* generally, Perlin, *supra* note 17.

83. *See* Perlin, *supra* note 17, at 602 (asking this question in the context of insanity defendants).

84. *See* A.B. JOHNSON, *supra* note 20, at 159.

85. *See* generally, Perlin, *supra* note 17, at 623-40.

86. *See* Lipton & Sabitini, *Constructing Support Systems for Homeless Chronic Patients*, in *THE HOMELESS MENTALLY ILL* 153, 155-56, (H.R. Lamb ed. 1984).

feeling and behavior patterns of response by an individual or by a society to . . . a mentally ill individual").⁸⁷ As I have recently written elsewhere:

To avoid dealing with issues of economic marginality and racial exclusion, we perpetuate symbolic stereotypes of mental illness that reify centuries of social myths and meta-myths and that have traditionally colored and shaped the ways we treat the mentally ill. We thus focus our attention upon a group of victims against whom there is significant social prejudice instead of questioning the societal problems that are the true sources of homelessness. In the end, it is precisely these "sanist" policies that best explain the moral bankruptcy of our treatment of the homeless mentally ill.⁸⁸

These social attitudes — reinforced by political and media distortions, and encouraged by the decade of greed that exemplified the Reagan years⁸⁹ — perpetuate our treatment of the homeless mentally ill: our social myopia, psychological brutality, and political cynicism.⁹⁰ We further perpetuate stereotypes, and thus avoid examining the fundamental economic and social questions that underlie the tragedy of homelessness and, specifically, the homeless mentally ill. We allow our discourse to be founded on myths to avoid the stark realities lurking just below the surface.

So, the next time you're at a cocktail party and talk turns to the homeless, don't blame Jan Costello (if you know her). Or me. I've had it. Blame Ronald Reagan.⁹¹ Better yet, if you voted for Reagan: blame

87. Birnbaum, *The Right to Treatment: Some Comments on Its Development*, in MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 97, 105-07 (F. Ayd ed. 1974). I discuss Birnbaum's theories in Perlin, *supra* note 4, at 91-93.

88. *Id.* at 111-12 (footnotes omitted).

89. See Karmel, *The Use of Prosecution (Again)*, 203 N.Y.L.J. (Dec. 20, 1990), at 3; see generally, Jahiel, *The Situation of Homelessness*, in THE HOMELESS IN CONTEMPORARY SOCIETY 99, 114-15 (R.D. Bingham ed. 1987) (discussing role of greed in attitudes toward the homeless).

90. Perlin, *supra* note 4, at 65.

91. See e.g., Hollings, *Bush's Real Problem — The Ruins of Reaganism*, Wash Post., Apr. 30, 1989, at C1, Col. 4 (Reagan Administration "hollow[ed] . . . out the federal government . . ."); Marmor & Gill, *supra* note 43, at 474 (Reagan era helped create socio-economic environment in which "large scale innovation for the socially

yourself. The shame of America⁹² is, when we get down to it, the fault of all of us. The fact that we fail to acknowledge this reality may be the biggest shame of all.

disfavored [became] practically unthinkable").

92. See *Homeless in America: Hearing Before the Subcommittee on Housing and Community Development of the House Committee on Banking, Finance and Urban Affairs*, 97th Cong., 2d Sess. 57 (1982) (statement of Robert Hayes).