ABSTRACT: Since the publication of Goffman's Asylums in 1961, major changes in the philosophy of treatment have been made within psychiatric facilities. While legislative and judicial action have done much to encourage community service provision and to protect the rights of prospective inpatients, long-term psychiatric patients have been neglected. Socialized into the lifestyle described by Goffman as the "total institution," the chronic patient lacks the skills and motivation to successfully adjust to community living. The needs of the long-term inpatient can be met through a nontraditional training model, but only if intervention is made on community, political, and staff levels as well.

In the early sixties, Erving Goffman published his now-classic Asylums (1961) based upon data collected in the early and mid-1950s. At that time, "warehousing" of individuals deemed to be in need of psychiatric treatment was common. Little legislative protection of civil and basic human rights was accorded the patient or prospective patient. Institutions, primarily those state or federally funded, were large. Dehumanizing conditions were frequently found. Therapeutic techniques questionable today, including a vague and loosely defined concept of milieu therapy, were in use. Goffman labeled these and other characteristics of the psychiatric service delivery systems he observed as part of a "total institution" framework.

Much has happened in the fifteen years since the publication of Asylums. While such institutions most certainly continue to exist, they are becoming smaller in number. They are, in addition, being made aware that the characteristics of patient treatment described by Goffman are no longer considered professionally or socially acceptable. Gradually, mental institutions have stopped being "asylums."

Populations of progressive institutions for the mentally ill are today comparatively small. The focus of the inpatient setting has changed from custodial to active treatment. Legal constraints limit the involuntary confinement of patients to such facilities and the medical model has greatly decreased in significance. Controversial therapeutic procedures,
such as electroconvulsive therapy, are seldom prescribed and, when used, are administered only after careful review and informed patient consent. The all-encompassing concept of milieu therapy has been replaced by individualized, goal-oriented treatment planning. Documentation of treatment needs and of their assessment, treatment plan development, and evaluation are mandated not only by facility regulations but, in many areas, by state law. Patients working within the hospital setting receive financial compensation equal to that of a hospital employee who might otherwise perform the same service. Opportunities for community and other social involvement, once considered privileges which might be earned by those patients who met staff standards of cooperativeness, are today considered the basic human rights of hospital residents. Legal counsel is provided free of charge, visits with family and friends are minimally restricted, access to community is provided as much as is consistent with the independent functioning level of the individual patient, and rights of due process are protected by both legal and administrative order.

The general trend toward protection of the mental patient’s rights, as seen in the aforementioned characteristics of new, progressive psychiatric facilities, has come about primarily through the court system rather than through the psychiatric community itself. *Wyatt v. Stickney* (1972) and *O’Conner v. Donaldson* (1975) have been significant in speaking to the individual patients’ right to minimum standards of treatment and to their right to freedom when neither treatment nor proof of danger to self or society is present. In many states, hospital policy and/or legislation has promoted the concept of “least restrictive environment.” This concept requires that mental patients may no longer be hospitalized against their will if a less restrictive treatment resource is appropriate. Thus, community mental health clinics and other outpatient facilities have received a mandate to provide comprehensive services which allow the individual, who might formerly have been admitted to an institution, to be offered the alternative to receive treatment without detention. In addition, recently passed legislation in several states requires that no prospective mental patient may be committed to any psychiatric facility unless there is proof by recent overt act that that individual is a significant danger to the physical safety of self or others. The prospective involuntary patient’s right to due process is protected, for the first time in many states, by a procedure which requires the provision of an attorney, notice of a planned hearing and of the circumstances delineated as cause for a petition for commitment, and opportunity to be present at the hearing and to testify in their own behalf as well as to question witnesses.

The movement of social policy, in the late 1960’s and early 1970’s, toward a concept of comprehensive community mental health care has also been significant. Through the power of federal funding, states across