have so many foreign carriers? Frank White, director of communications and systems for the Air Transport Association, says, "Since there already were hundreds of knobs and dials and switches in the plane, there was serious doubt in our minds that ground prox would make a serious contribution to safety. Would another warning device make any difference?"

This argument is specious, at best. Ground prox has logged well over 500,000 flight hours without an accident; exhaustive studies show that it would have prevented at least 85 percent of all CFIT crashes since 1969. Reduced insurance premiums alone could cover the purchase and installation costs in less than six months. The system's average price tag of $10,000—installation is included—makes ground prox for a 747 comparable to an extra side-view mirror for your new car.

Two hopeful signs: despite its financial problems, Pan Am began putting the warning systems on its entire 134-plane fleet last spring, and Braniff began retrofitting its planes last fall. But it's apparent that a mandatory ruling will have to be made before the giants like United follow suit. So, even if the FAA sticks with Butterfield's "probable" timetable, you'll have to wait until October 1976 before you can be sure the plane you're on is protected by ground prox. That's just about six years after NTSB's first recommendation.

Testimony at the House Commerce Committee hearings showed that each year roughly 500 passengers and crew members die in CFIT crashes—which means that about 3,000 people have been killed and $750 million in airline profits has gone down with them (liability suits, hull losses, increased insurance premiums) since FAA first got the word that ground proximity warning devices might be a good idea.

Would you call it "footdragging"? Commerce Committee members seemed to think so. J. J. Pickle of Texas cited the "cold fact" that twenty-three CFIT crashes of commercial airliners have killed 1,200 people since January 1972. "I think every member of this committee would say you have to proceed carefully, but when in the space of a little over two years we have lost 1,200 people, then it would seem to me that time becomes more important than procedure." Pickle asked whether "the FAA is not exercising more caution, more hesitancy and even concern for manufacturers than they are for safety." Chairman Harley Staggers added: "I don't know of any other agency of government or private industry or any other place in the world that would take that long with people's lives."

—Terry King
North Bend, Washington

COMMUNITY MENTAL HEALTH: GOOD INTENTIONS RUN AMOK

Three cheers. They're closing down the snake pits; they're opening up the wards. Hooray, hooray. They'll discharge anyone who can sign his name and a few who can't. Everyone knows state mental hospitals are awful, so freeing everyone, even those who want to stay, must be for the best.

The name of the game is Community Mental Health, a system designed to maintain patients in the community in order to spare them the stigma and other dreadful consequences of institutionalization. Therapy will be taken care of in health centers and halfway houses. Many states have already begun such programs; their popularity makes it look as if the nation's large state hospitals will be phased out.

Mental illness is something everyone would just as soon didn't exist; the temptation to declare it nonexistent or to deemphasize its seriousness has always been strong. Until recently this temptation has been balanced by the cold hard fact of the matter: people go crazy, and not just a few and not just a little crazy. But the escapist impulse has recently gained powerful allies in the form of "ex-

Mark Vonnegut, currently a premed student at the University of Massachusetts, is the author of The Eden Express, an account of schizophrenia, to be published by Praeger next fall.
of Community Mental Health centers, halfway houses, rehabilitative counseling, vocational training, and associated services; and (2) the phasing out of large state hospitals. For lack of money, staff, and planning, the constructive parts of the program haven’t gotten off the ground. There are a few showcases, but by and large the promised services have failed to materialize and show little hope of doing so in the reasonably near future. Despite this, part two is proceeding full speed ahead.

Keeping patients within the community has recently become a virtual article of faith among mental-health experts; hospitalization is to be avoided at all costs. Supposedly, this prevents the patient from lapsing into institutionalized stupor, saves him from the stigma of having been a mental patient, and keeps him in contact with his society. It’s undoubtedly a wise policy in some cases, but the lengths to which it is being taken are utterly absurd, even destructive. Prior to his seeking admission to a hospital, the patient is often already in an “institutionalized stupor” and in minimal contact with society.

So what happens to these patients whose freedom is restored? Vocational training or counseling? Halfway houses? A little help finding housing? Maybe for some, but the vast majority of patients are discharged with little more than a friendly pat on the back. If they’re lucky someone will explain how to apply for welfare. And then what? Apparently there is such faith in this program that no one has bothered to do very much by way of follow-up studies. What scraps of information we have are not very encouraging. The suicide rate is high. Some former patients kill themselves more subtly, with alcohol, drugs, or by simply failing to take care of their most basic health needs. Unemployment and welfare statistics are staggering, perhaps in the 90 percent range. Many former patients hole up in welfare hotels or shabby apartments whose squalor rivals and often surpasses conditions in the worst of our back wards. For all the therapeutic interaction going on between them and the community, they might just as well be back in the hospital, except that meals came regularly, routine health problems were checked, and every once in a while someone would see how they were doing. A few patients make it out in the community; many more don’t.

If hospitalization is such a dreadful thing, one wonders why the rich are still using it, and letting the poor have such a marvelous new system of maintenance in the community. Hospitalization—getting the hell out of the community, the family, the job—is often an essential part of getting well. For all the millions of things we don’t know about mental illness, we do know that the stress and responsibility of day-to-day living and “trying to act normal” aggravate it and hinder recovery. With the coming of Community Mental Health, the only place one will be able to get locked up will be in ritzy private hospitals.

There is a growing tendency to see the problems of the insane philosophically, sociologically, or religiously rather than medically. This leads to superficial notions—for example, that insanity is understandable and perhaps even a proper response to the spiritual sickness of our society, or that the insane are weaklings and escapists unable or unwilling to face reality, notions which are totally unsupported by the history and statistics of insanity. In a sense, what these romantic views lead to is dismissal of the sick. To tell someone suffering from emphysema to come off it and start breathing right would be absurd, but this is essentially what we are doing to those suffering from severe mental illness. By denying the problem, we eliminate one of the few kind things we can do for the mentally ill—to give them a break and free them from the notion that they are either faking it or are somehow responsible for their own suffering. If there is anything worse than being insane, it’s being insane and being told there is nothing wrong with you.

I have no doubt that many proponents of Community Mental Health are well intentioned, and that the program as they envision it would be a vast improvement over state hospitals. But they need adequate funding for the establishment of halfway houses, vocational training, and related services. None of this has happened. As the system is being put into effect, the emphasis is on closing the big hospitals. This saves money, looks liberal, and ignores several alarming problems.

I have two modest proposals: first, that adequate studies be made of the recently discharged patients, and, second, that the wholesale discharges be stopped or at least slowed down until some of the more constructive aspects of the program are operating. It is essential that Community Mental Health not be carelessly unleashed on the public; it should be tested as carefully as if it were a new drug.

—Mark Vonnegut
Boston, Mass.