To Subscribe: https://fulfillment.healthaffairs.org

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution
MENTAL HEALTH POLICY IN AMERICA: MYTHS AND REALITIES

by Gerald N. Grob

Prologue: Before World War II the focus of America's efforts to treat its mentally ill citizens was on those individuals who suffered from the most severe and chronic problems. Since 1960 public policy has emphasized creation of a decentralized system of services. In the process, the target population became diffuse, and services were no longer focused on the most severely ill people. In this review Gerald Grob, Henry E. Sigerist Professor of the History of Medicine at Rutgers University, discusses this important policy shift and its consequences. Grob, who holds a doctorate in American history from Northwestern University, has devoted most of his career to an examination of the way America treats its mentally ill citizens. He was attracted to this subject thirty-two years ago while teaching at Clark University in Worcester, Massachusetts, where one of the state's mental hospitals was located. Grob learned that the hospital had maintained the case histories of every patient admitted to the institution since 1830. Exploiting this fascinating archive, Grob produced a book in 1966 that was a study of this state mental hospital from 1830 to 1920. Since then he has written a trilogy that serves as the definitive history of America's treatment of the mentally ill. His first work, entitled Mental Institutions in America: Social Policy to 1875, was published in 1973. The second volume, Mental Illness and American Society, 1875–1940, was published in 1983. The third volume, published in 1991, is entitled From Asylum to Community: Mental Health Policy in Modern America; it is reviewed in this volume of Health Affairs. Because of his pathfinding work, Grob has garnered many honors, including a Guggenheim Fellowship, two fellowships from the National Endowment for the Humanities, election to the Institute of Medicine of the National Academy of Sciences, and the William H. Welch Medal of the American Association for the History of Medicine in 1986.
In mid-nineteenth-century America the asylum was widely regarded as the symbol of an enlightened and progressive nation that no longer ignored or mistreated its insane citizens. The justification for asylums appeared self-evident: They benefited the community, the family, and the individual by offering effective medical treatment for acute cases and humane custodial care for chronic cases. In providing for the mentally ill, the state met its ethical and moral responsibilities and, at the same time, contributed to the general welfare by limiting, if not eliminating, the spread of disease and dependency. After World War II, by way of contrast, the mental hospital began to be perceived as the vestigial remnant of a bygone age. Increasingly, the emphasis was on prevention and the provision of care and treatment in the community. Indeed, many mental health professionals during the 1960s were fond of referring to a new psychiatric revolution equal in significance to the first revolution begun by Philippe Pinel, who allegedly removed the chains of Parisian lunatics in 1793. The new policy, in short, virtually abolished traditional mental hospitals and created new community alternatives.

The elements that shaped the transition from an institutional to a community-based policy are more complex than is commonly recognized, for the foundations of change had their origins in the late nineteenth century. Public policies, after all, are more often than not evolutionary in nature; only rarely do they emerge in some novel form following a cataclysmic event. Mental health policies were no exception; the changes that occurred after 1945 were linked with earlier developments.

**Origins Of Change**

**Patient population.** Of major significance in preparing the foundations for new community-oriented policies was the change in the nature of the patient population of mental hospitals after 1890. The proportion of long-term or chronic cases in hospitals between the 1830s and 1870s was relatively low as compared with the extraordinary high percentage between 1890 and 1950. Although national data are lacking, a sample of individual hospitals reveals that their functions as custodial institutions had not yet become dominant. The experiences of Worcester State Hospital—the oldest and most important public institution in Massachusetts—are instructive. In 1842 (a decade after it opened) 46.4 percent of its patients had been hospitalized for less than a year; only 13.2 percent had been in the hospital for five or more years. The comparable figures in 1870 were 49.6 percent and 13.9 percent. Nor was Worcester atypical. Unlike their twentieth-century counterparts, hospitals before 1880 did not have large numbers of two classes of patients: the aged
MENTAL HEALTH POLICY 9

(over age sixty-five) and paretics (the tertiary stage of syphilis). Aged patients accounted for only about 5 to 10 percent of the total between 1830 and 1875. Only 2.7 percent of all patients admitted to the Utica Hospital between 1850 and 1868 were afflicted with general paresis.¹

In general, mid-nineteenth-century patients who were discharged as recovered or improved tended to be institutionalized for only brief periods, from three to nine months. Hence, the prevailing belief was that a mental hospital with 200 beds could treat approximately 600 patients during a twelve-month period. Surviving evidence suggests that the claims of therapeutic successes had some validity. Although affirmations about curability rates were undoubtedly exaggerated, there is little doubt that many individuals appeared to benefit from hospitalization. In the 1880s an enterprising superintendent undertook a follow-up study of over a thousand patients discharged as recovered on their only or last admission. The study took more than a decade to complete, and in the end data were accumulated on 984 individuals. Of these, 317 were alive and well at the time of their last reply, while 251 who had died had never again been institutionalized. Thus, nearly 58 percent of those discharged as recovered had functioned in the community without relapse.²

Funding patterns. The low proportion of chronic patients in mental hospitals was due in part to the pattern of funding. In general, state legislatures provided the capital funds necessary for acquiring new sites and constructing, expanding, and renovating existing physical plants. Local communities, on the other hand, were required to pay hospitals a sum equal to the actual cost of care and treatment of each patient admitted. The system, moreover, did not assume that every mentally ill person would be cared for in a state institution. Laws generally required that only dangerous mentally ill persons had to be sent to state hospitals. Others who could presumably benefit from therapeutic interventions (and thus ultimately be removed from welfare rolls) could, at the discretion of local officials, also be institutionalized. The system, in short, divided responsibility between state and local authorities.

For much of the nineteenth century, therefore, a significant proportion of insane persons either continued to live in the community or were kept in municipal almshouses. Families with sufficient resources could commit their relatives to state institutions, provided the families were willing to assume financial liability for the patient’s upkeep. States, moreover, had to reimburse hospitals for those patients who had not established legal residency. The result was a variegated pattern. Edward Jarvis’s census of all persons identified by others as insane in Massachusetts in 1854 provides some insight into the distribution of the mentally ill. In his monumental survey, Jarvis identified by name every insane
person in the Bay State. According to his final tabulations, there were 2,632 insane persons. Of this number, 1,522 were paupers, and 1,110 were supported by their own resources or by friends. At the time, 1,284 were either at home or in local almshouses; 1,141 were in hospitals; and 207 were in local receptacles for the insane, houses of correction, jails, or state almshouses. Only 435 were identified as curable, as compared with 2,018 as incurable (the prognosis of 179 was unknown).

Divided responsibility for the mentally ill had significant repercussions. The system tended to promote competition and rivalries between overlapping governmental jurisdictions. In many states the stipulation that communities were financially liable for their poor and indigent insane residents created incentives for local officials to keep them in almshouses, where costs were lower. Hospital officials often faced unremitting pressure to discharge patients—regardless of their condition—to save money. Local officials on occasion even attempted to force hospitals to reimburse the community for work performed by patients, although such labor was part of a therapeutic regimen. Ironically, divided fiscal and governmental authority had the paradoxical effect of keeping the chronically ill population in mental hospitals at relatively low levels.

State-level policies. As the number of chronic patients increased, however, states slowly began to reconsider their policies. Disillusioned by a system that divided authority, states—led once again by New York and Massachusetts—adopted legislation that relieved local communities of any role whatsoever in caring for the mentally ill. The assumption of those who favored centralization was that local care, although less expensive, was substandard and also fostered chronicity and dependency. Conversely, care and treatment in hospitals, though more costly at first, would be cheaper in the long run because it would enhance the odds of recovery for some and provide more humane care for others.

Although the intent of state assumption of responsibility was to ensure that the mentally ill would receive a higher quality of care and treatment, the consequences in actual practice turned out to be quite different. In brief, local officials saw in the new laws a golden opportunity to shift some of their financial obligations onto the state. The purpose of the legislation was self-evident—namely, to remove the care of the chronic mentally ill from local jurisdiction. But local officials went beyond the intent of the law. Traditionally, nineteenth-century almshouses (which were supported and administered by local governments) served in part as old-age homes for senile and aged persons without any financial resources. The passage of state care acts provided local officials with an unexpected opportunity. They proceeded to redefine senility in psychiatric terms and began to transfer aged persons from
local almshouses to state mental hospitals. Humanitarian concerns played a relatively minor role in this development; economic considerations were of paramount significance.

Faced with an opportunity to shrink expenditures, communities were more than happy to transfer responsibility for their aged residents to state-supported facilities. Between 1880 and 1920, for this and other reasons, the almshouse populations dropped precipitously. Admissions fell from 99.5 to 58.4 per 100,000 between 1904 and 1922. The decline in the number of mentally ill persons age sixty and over living in almshouses was even sharper, dropping from 24.3 percent in 1880 to 5.6 percent in 1923. This was not a deinstitutionalization movement, but rather a lateral transfer of individuals from one institution to another. “We are receiving every year a large number of old people, some of them very old, who are simply suffering from the mental decay incident to extreme old age,” observed Charles C. Wagner (superintendent of the Binghampton State Hospital in New York) in moving terms in 1900. “A little mental confusion, forgetfulness and garrulity are sometimes the only symptoms exhibited, but the patient is duly certified to us as insane and has no one at home capable or possessed of means to care for him. We are unable to refuse these patients without creating ill-feeling in the community where they reside, nor are we able to assert that they are not insane within the meaning of the statute, for many of them, judged by the ordinary standards of sanity, cannot be regarded as entirely sane.”

Changes in mental hospitals. During the first half of the twentieth century, as a result, the character of mental hospitals changed dramatically. Before then, hospitals had substantial turnover rates, even though they retained patients who failed to improve or recover. In the four decades following the opening of Utica State Lunatic Asylum in the 1840s, the proportion of patients who left the New York institution hovered around 40 percent. In the twentieth century, by way of contrast, the pattern changed markedly as the proportion of short-term cases fell and those of long-term increased. In 1904, 27.8 percent of the nation’s total patient population had been institutionalized for twelve months or less. This percentage fell to 12.7 by 1910, rising to 17.4 in 1923. The greatest change, however, came among patients hospitalized for five years or more. In 1904, 39.2 percent of patients fell into this category; in 1910 and 1923 the respective percentages were 52.0 and 54.0. Although data for the United States as a whole are unavailable after 1923, the experiences of Massachusetts are illustrative. By the 1930s nearly 80 percent of its mental hospital beds were occupied by chronic patients. Chronicity, however, is a somewhat misleading term for the heterogeneous group that it described. The aged (over age sixty or sixty-five)
constituted by far the single largest component. By 1920, for example, 18 percent of all first admissions to New York State mental hospitals were diagnosed as psychotic because of senility or arteriosclerosis; twenty years later the figure had risen to 31 percent. A decade later 40 percent of all first admissions were age sixty and over, compared with only 13.2 percent of the state population. The increase in the absolute number also reflected a change in age-specific admission rates. In their classic study of institutionalization rates over more than a century, Herbert Goldhamer and Andrew Marshall found that the greatest increase occurred in the older category. As late as 1958 nearly a third of all resident state hospital patients in the nation were over age sixty-five.\(^7\)

The rising age distribution mirrored a different but related characteristic of the institutionalized—namely, the presence of large numbers of patients whose abnormal behavior reflected underlying physical causes. Even allowing for imprecise diagnoses and an imperfect statistical reporting system, it was quite evident that a significant proportion of the hospitalized population suffered from severe organic disorders for which there were no effective treatments. Of 49,116 first admissions in 1922 admitted because of various psychoses, 16,407 suffered from a variety of identifiable somatic conditions (senility, cerebral arteriosclerosis, paresis, Huntington’s chorea, brain tumors, and so on). Between 1922 and 1940 the proportion of such patients increased from 33.4 percent to 42.4 percent. Various forms of senility and paresis accounted for about half of all first admissions in 1946.\(^8\)

The change in the character of mental hospitals also altered their links with psychiatry. Trained as physicians, psychiatrists clearly preferred a therapeutic role to a custodial one. Yet the institutional context in which they practiced in the early twentieth century was hardly conducive to the pursuit of the former. Moreover, the rise of modern “scientific” medicine appeared to accentuate still further the seemingly obsolescent character of psychiatry. Thus it was understandable that psychiatrists between 1890 and World War II began to redefine concepts of mental disorders and therapeutic interventions, as well as the very context in which they practiced. In so doing, they began to distance themselves from traditional mental hospitals, which—unlike their nineteenth-century predecessors—had large numbers of chronic and aged patients whose need for general care was paramount.

---

**The Emergence Of The Community**

By the mid-1940s it was clear that the character of mental hospitals had been transformed by the nature of their patient populations. The
presence of so many aged persons and patients suffering from irreversible somatic disorders, for example, signified that institutions were providing custodial care for those who would remain until they died."

**Attacks on mental hospitals.** In the immediate postwar years journalists and mental health professionals alike published numerous critical accounts of mental hospitals, even though their analyses were not always accurate. Admittedly, a decade and a half of financial neglect, due largely to the combined impact of the Great Depression of the 1930s and global conflict of the 1940s, simply exacerbated severe problems that already existed. The depressing state of mental hospitals, however, was as much a function of the nature of their patients as it was the result of parsimonious or callous policies. The large number of chronically ill patients was undoubtedly the single most significant element in shaping a milieu seemingly antithetical to therapeutic goals.

Mental hospitals— institutions that had been the cornerstone of public policy for nearly a century and a half— slowly began to lose their social and medical legitimacy. This was hardly surprising. Indeed, after World War II the prevailing consensus on mental health policy slowly began to dissolve. Developments converged to reshape public policy during these years. First, there was a shift in psychiatric thinking toward a psychodynamic and psychoanalytic model emphasizing life experiences and the role of socioenvironmental factors. Second, the experiences of World War II appeared to demonstrate the efficacy of community and outpatient treatment of disturbed persons. Third, the belief that early intervention in the community would be effective in preventing subsequent hospitalization became popular. Fourth, a faith developed that psychiatry could promote prevention by contributing toward the amelioration of social problems that allegedly fostered mental diseases. Fifth, the introduction of psychological and somatic therapies (such as psychotropic drugs) held out the promise of a more normal existence for patients outside of mental institutions. Finally, an enhanced social welfare role of the federal government not only began to diminish the authority of state governments but also hastened the transition from an institutionally based policy to a community-oriented one.

**Role of psychiatry.** Winds of change were evident well before the widespread use of psychotropic drugs or the advent of "deinstitutionalization" (an often misunderstood and misleading term). The specialty of psychiatry, long synonymous with institutional care, rapidly changed its character in the postwar era. To be sure, psychiatrists began to find careers outside of public institutions in the interwar decades. But after 1945 there was a mass exodus of psychiatrists from mental hospitals into private and community practice. Within a decade, more than 80 percent
of the 10,000 members of the American Psychiatric Association (APA) were employed outside of mental hospitals. Their positions were filled by foreign medical graduates with little or no training in psychiatry. Although the APA staff continued to work with public hospitals (especially through the Central Inspection Board, annual Mental Hospital Institutes, and their willingness to conduct surveys in individual states), they were neither knowledgeable about nor sympathetic toward their institutional colleagues and often emphasized the desirability of non-institutional alternatives. Moreover, most psychiatrists in the community treated large numbers of patients with psychological problems, and thus their contacts with the severely mentally ill were sharply reduced. That hospitals had a large proportion of chronic patients hardly accorded with the self-image of the psychiatrist as an active and successful therapist. In his APA presidential address in 1958, Harry C. Solomon even described the large mental hospital as “antiquated, outmoded, and rapidly becoming obsolete.” Robert C. Hunt, director of the Hudson River State Hospital in New York and an individual deeply concerned with institutional problems, responded publicly in critical terms. His “private reactions are still unprintable,” he wrote to Solomon. Hunt then informed the APA Commission on Long-Term Planning that the organization had not played a constructive role in countering the detrimental effects associated with “the state hospital stereotype.” The majority of APA members, he added in revealing terms, had neither the contacts with nor knowledge about mental hospitals. Hence, its members were prone to identify the prevailing stereotype with reality; the result was a virtual abandonment of the hospital by American psychiatrists.

Strengthening community care. The weakening of long-established links between hospitals and psychiatrists was accompanied by a movement to strengthen outpatient and community clinics. Before 1940 such clinics had dealt predominantly with children, not adults. The postwar enthusiasm for clinics received momentum with the passage of the National Mental Health Act of 1946, which provided grants to states to support existing outpatient facilities or to establish new ones. The ultimate goal, according to Robert H. Felix, first director of the National Institute of Mental Health (NIMH), was one outpatient facility for each 100,000 persons. Although appropriations were modest, their impact was dramatic. Before 1948 more than half of all states had no clinics; by 1949 all but five had one or more. Six years later there were about 1,234 outpatient psychiatric clinics, of which about two-thirds were supported or aided by states. Psychiatrists proved staunch proponents of a community-oriented policy, for they insisted that early identification and treatment in outpatient facilities or private offices diminished the need for
subsequent hospitalization and were cost-effective. Support for a community-based policy increased steadily during the 1950s; the Governors’ Conference and Council of State Governments, as well as private foundations such as the Milbank Memorial Fund, played important roles in marshalling support for innovation. In 1954 New York enacted its influential Community Mental Health Services Act, which provided state funding for outpatient clinics; California followed suit shortly thereafter with the passage of the Short-Doyle Act. By 1959 there were more than 1,400 clinics serving about 502,000 individuals, of whom 294,000 were over age eighteen. The expansion of community facilities was accompanied also by new services to schools, courts, and social agencies by nonmedical mental health professionals. This development offered further proof of the degree to which the public sought, if not demanded, access to psychiatric and psychological services in noninstitutional settings. During these years Felix and his NIMH colleagues used their links with key congressional figures to enhance the policy-making authority of the federal government as a vehicle to strengthen community policies.

Many of the claims about the efficacy of community care and treatment, however, rested on extraordinarily shaky foundations. The presumption was that outpatient psychiatric clinics could identify early cases of mental disorders and also serve as alternatives to mental hospitals. The empirical data to validate such assertions, however, were lacking. Indeed, a study of about 500 patients in three California state hospitals during the 1950s found most of them unsuited to treatment in clinics. The authors found “marked discontinuities in functions of the participating hospitals and clinics and the difficulties in initiating outpatient treatment with hospitalized patients shortly after their admission.” They also called attention to “the value of services to bridge the gap between the traditional functions of hospitals and clinics for already hospitalized patients.” Data collected by Morton Kramer and his associates at the NIMH Biometrics Branch raised equally serious problems. A community policy was based on the expectation that patients could be treated outside of institutions. Underlying this belief were several assumptions: (1) patients had a home; (2) patients had a sympathetic family or other person willing and able to assume responsibility for their care; (3) the organization of the household would not impede rehabilitation; and (4) the patient’s presence would not cause undue hardships for other family members. In 1960, however, 48 percent of the mental hospital population were unmarried, 12 percent were widowed, and 13 percent were divorced or separated. A large proportion of patients, in other words, may have had no families to care for them. Hence, the
assumption that patients could reside in the community with their families while undergoing rehabilitation was hardly realistic.15

Such findings fell on deaf ears; the rhetoric of community care and treatment carried the day in the 1950s and 1960s. Too often, exaggerated claims have been overlooked or ignored. Yet rhetoric cannot be dismissed so easily: It shaped agendas and debates; it created expectations that in turn molded policies; and it informed the socialization, training, and education of those in professional occupations. From the creation of the Joint Commission on Mental Illness and Health in 1955 and the publication of its influential Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health, 1961 to the passage of the Community Mental Health Centers Act of 1963, the advocates of a community-oriented policy succeeded in forging a consensus regarding the desirability of diminishing the central role of mental hospitals and strengthening community facilities. They were joined by a variety of other individuals and groups. Psychiatric critics (such as Thomas Szasz) attacked the legitimacy of the concept of mental illnesses; civil rights advocates identified the mentally ill as a group systematically deprived of constitutional liberties; and social activists emphasized that institutions such as mental hospitals could never be other than repressive and dehumanizing. The result was a determined and partially successful effort to reshape public policy by diminishing the role of hospitals and enhancing outpatient and community services.

During the 1960s the attack on the legitimacy of institutional care began to bear fruit. Hospital populations declined rapidly after 1965. A shift in thinking had made community care, at least in theory, an acceptable alternative to institutionalization. Administrative and structural changes within institutions, including open-door policies, informal admissions, and efforts to prepare patients for early release, as well as the introduction of psychotropic drugs, reinforced the faith in the efficacy of community treatment. The passage of Medicaid and Medicare, moreover, hastened the exodus of aged patients from hospitals to nursing homes. The rapid expansion of third-party reimbursement plans stimulated the use of inpatient and outpatient psychiatric services in general hospitals. Ironically, the reduction of the patient population no doubt improved the lives of those who remained in public mental hospitals.

Shift in location of services. Nowhere were the changes in the mental health system during the 1960s more visible than in the aggregate data dealing with patient care episodes.16 There were 1,675,352 patient care episodes in 1955; 22.6 percent were treated in outpatient facilities; 48.9 percent in state mental hospitals; and the remainder in other institutions. Of 3,380,818 episodes in 1968, 52.7 percent were
treated in outpatient facilities (of which 8 percent were in community mental health centers [CMHCs]), 23.4 percent in state hospitals, and 23.9 percent in other institutions. Put another way, 77.4 percent of episodes were treated in inpatient facilities in 1955 and 22.6 percent in outpatient settings; thirteen years later the respective figures were 47.3 percent and 52.7 percent. In sum, there was a profound shift in the location of services as well as an increase in the rate of episodes. In 1955 there were 1,028 episodes per 100,000; by 1968 this figure had risen substantially to 1,713.17

The change in the location of services, however, did not mean that public mental hospitals were on the road to extinction and that community outpatient centers and clinics were assuming their functions. On the contrary, outpatient facilities grew rapidly because they were used by new groups that in the past had no access to the mental health system and who were for the most part not in the severely mentally ill category. Thus, while the rate of inpatient care episodes at public hospitals declined from 502 to 401 per 100,000 between 1955 and 1968, outpatient care episodes leaped from 233 to 901. In absolute terms, inpatient care episodes at public institutions in the same period fell from 818,832 to 791,819, whereas outpatient care episodes increased from 379,000 to 1,778,590. These data demonstrate that the growth in outpatient services was not at the expense of inpatient ones. Many of the changes in the mental health system occurred because of the expansion of services and recruitment of a new clientele.

The dramatic growth of outpatient facilities diminished the relative significance of public mental hospitals, which had been central to the mental health system for more than a century. The number of resident patients fell slowly from 1955 to 1965 and more rapidly thereafter. Yet at the same time the number of admissions was increasing. In 1955, 178,003 persons were admitted to state and county mental hospitals. A decade later the figure was 316,664. The rapid decline in the resident population after 1965 did not alter this pattern; there were 384,511 admissions in 1970. These figures suggest that an important change in the function of state hospitals had taken place. During the first half of the twentieth century these institutions cared for large numbers of chronic cases drawn from several categories. The number of aged and chronic patients began to fall by the late 1960s) and mental hospitals then began to provide more short- and intermediate-term care and treatment for severely mentally ill persons.18

To be sure, the number of patient care episodes treated in general hospitals (with and without psychiatric units) and federally funded CMHCs increased, although there were sharp variations from place to
place. The available (and imperfect) data, however, indicate that these facilities did not generally treat individuals previously admitted or likely to be admitted to mental hospitals. There were, for example, some striking differences in diagnostic categories. In 1969 state hospitals had a higher proportion of patients with schizophrenic reactions, a group that constituted the core of the severely mentally ill group. Nearly 30 percent of its admissions were in this category; 11 percent were in the organic brain syndrome, and 10.2 percent in the depressive categories. General hospital inpatient services, by way of contrast, treated different kinds of patients. More than a third of their admissions suffered from depressive disorders; schizophrenic reactions accounted for 17.2 percent, and organic brain syndromes, 6.5 percent.19

The differences between state mental and general hospitals with specialized units becomes even clearer from length-of-stay data. The mean and median stay in general hospitals in 1963 was twenty and seventeen days, respectively. These figures fell slightly during the 1960s) the former to seventeen in 1969 and the latter to eleven in 1971. By 1975 the mean stay was only 11 days, and the median, 6.7 days.20

The pattern in state mental hospitals differed substantially. Unfortunately, length-of-stay data were not reported before 1970. Other data, however, shed light on the functions of these institutions. Data from twenty-three states in 1962 revealed that the median stay for patients resident at the end of the year was 8.4 years. The distribution was even more striking: 18.4 percent of patients were institutionalized for less than a year; 22 percent, from one to four years; 14.6 percent, from five to nine years; 20.4 percent, from ten to nineteen years; and 24.6 percent, twenty years or more.21 The number of long-term patients at public institutions fell precipitously after 1965, largely because changes in funding patterns led to a sharp decline in elderly and chronic patients. This is not in any way to imply that state hospitals no longer provided long-term care. On the contrary, state hospitals remained what three investigators termed “the place of last resort” for perhaps 100,000 individuals for whom no alternative facility was available. Thus, in 1969 the mean stay of discharged patients at public hospitals was 421 days; six years later the corresponding figure was 270 days. Median length-of-stay data, however, reveal a quite different situation. In 1970 the median length-of-stay for admissions (and excluding deaths) was forty-one days; five years later this figure had dropped to twenty-five days. These data suggest that public institutions continued to treat and care for more severely and chronically ill persons than any other kind of institution. Indeed, in 1969 and 1975 they accounted for 79.4 percent and 67.2 percent, respectively, of all days of inpatient psychiatric care.22
Conclusion

The consequences of human activities tend to be complex and unpredictable; ambiguity—not clarity or consistency—is often characteristic. This is especially true for the changes in the mental health system since World War II. Prior to 1940 the focus of public policy had been almost exclusively on the severely and chronically mentally ill. This policy was based on the assumption that society had an obligation to provide such unfortunate persons with both care and treatment in public mental hospitals. The policies adopted during and after the 1960s rested on quite different assumptions. That public mental hospitals continued to play an important role is indisputable. The creation of a decentralized and heterogeneous system of services, however, diminished their relative significance. Equally important, the target population became more diffuse and variegated; the system was no longer concerned solely with the severely and chronically mentally ill. Even those professionals involved in providing services were less likely to deal with a group that presented formidable and sometimes insoluble problems. Ironically, the growing availability, variety, and popularity of mental health services sometimes worked to the detriment of those most in need.

Perhaps one of the most striking results of the postwar shift in policy was the breaking of the traditional and hitherto inseparable ties between care and treatment. Despite monumental shortcomings, mental hospitals had provided at least a basic level of care for many individuals incapable of functioning as independent and self-reliant human beings. Moreover, mental hospital care had derived legitimacy from its identification with medical science. Thus these institutions did not have to bear the burden of being tied to the welfare system.

The community mental health policies that emerged during the postwar decades inadvertently distorted priorities by strengthening the distinction between care and treatment. Admittedly, these policies paid rhetorical homage to the need for care. Reality, however, was quite different. The main focus was on providing therapeutic services in outpatient settings to a broad rather than a defined population. Consequently, the social and human needs of the most severely and especially chronically mentally ill—particularly assistance in dealing with the subsistence tasks of daily life—were often ignored or overlooked. The identification of mental health policy with therapeutic services was understandable, given the obvious advantages of being included within the medical health care system. Caring and support services, by way of contrast, were affiliated with a welfare system that by the 1970s and 1980s was under attack by a political constituency bent on diminishing...
governmental responsibilities and activities.

Why was there such a divergence between expectations and the actual consequences of new policies? The most frequently offered answer emphasizes the failure to provide the mental health system with adequate resources. Such a response, however, is both simple-minded and somewhat inaccurate; more often than not, it represents an understandable but misguided effort to shift culpability. This is not in any way to argue that American society is blameless. It is only to insist that divergence between expectations and reality results from a variety of complex and interacting elements.

When one is describing and analyzing mental health policy, the analogy of the concept of “impure science” is perhaps appropriate. When uncertainty rather than certainty prevails, wider latitude is given to the play of external and even seemingly extraneous or unconscious elements. The absence of knowledge, moreover, rarely inhibits individuals from advancing allegations that have but little basis in fact. On the contrary, policy innovations based on theory and hope rather than fact are debated (although always with the rationalization that they are justified by empirical data). Under such circumstances, it is hardly surprising that the outcomes of innovation often have little to do with initial expectations. Nowhere is the accuracy of this generalization better illustrated than in the evolution of mental health policy.

The research for this paper was supported by Grant no. MH39030 from the National Institute of Mental Health (NIMH)

NOTES

2. Worcester State Lunatic Hospital, Annual Report 61 (1893), 70.
3. E. Jarvis, Report on Insanity and Idiocy in Massachusetts by, the Commission on Lunacy under Resolve of the Legislature of 1854, Massachusetts House Document no. 144 (1855) (Boston: William White, 1855), 18, 73. All of the manuscript returns listing every person by name can be found in “Report of the Physicians of Massachusetts: Superintendents of Hospitals . . . and Others Describing the Insane and Idiotic Persons in the State of Massachusetts in 1855, Made to the Commissioners on Lunacy,” manuscript volume in the Countway Library of Medicine, Harvard Medical School, Boston, Massachusetts.


14. H. Sampson et al., “Feasibility of Community Clinic Treatment for State Mental Hospital Patients,” Archives of Neurology and Psychiatry 80 (1958): 77. A larger version of this study appeared under the title A Study of Suitability for Outpatient Clinic Treatment of State Mental Hospital Admissions, 1957, California Department of Mental Hygiene, Research Report 1 (1957).


16. The term patient care episode represents the sum of two numbers: residents at the beginning of the year or on the active role of outpatient clinics, and admissions during the year. The first is an unduplicated count; the second includes duplications, since some individuals had multiple admissions.

17. Data taken from NIMH Statistical Note 23 (April 1970): 1–4, and NIMH Statistical Note 154 (September 1980): 12. Slight differences in totals are due to the rounding out of fractions. It should be noted that NIMH data usually did not count patient care episodes in general hospitals without specialized psychiatric units.

18. NIMH data in Kramer, Psychiatric Services and the Changing Institutional Scene, 78.


23. The concept of “impure science” has been used by Arthur Silverstein in his Pure Politics and Impure Science: The Swine Flu Affair (Baltimore: The Johns Hopkins University Press, 1981).