

# The Paradox of Deinstitutionalization

Gerald N. Grob

“**D**einstitutionalization” is a word that conjures up different meanings. In the 1970s it had a positive connotation: the term referred to the discharge of long-term psychiatric patients from obsolete custodial mental hospitals that had seemingly outlived their usefulness. The presumption was that seriously mentally ill persons could make a successful transition to community life with appropriate social and psychiatric support systems. Two decades later, deinstitutionalization has a more ambivalent character, for it suggests an image of homeless former mental patients who inhabit the streets of virtually every major urban area and seem to threaten the community as well as themselves.

Why has the solution of the 1970s become the problem of the 1990s? Has deinstitutionalization as a policy failed to live up to the optimistic expectations that accompanied its inauguration? The answers to these questions are by no means simple or clear-cut. Reality is far more complex than the images so frequently employed in the press or on television. To be sure, our perceptions are often shaped by figures like Larry Hogue, the individual who terrorized a block in upper Manhattan and was in and out of institutions on numerous occasions. But do these images correspond to reality? Perhaps the best way of understanding deinstitutionalization is to begin with an analysis of the evolution of mental health policy in the decades following World War II when the foundations for change were first laid.

## Mental Health Policy since World War II

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 psychological and 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 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, the prevailing assumption was that traditional mental hospitals would disappear as community alternatives and institutions came into existence. Immediately following the end of the war, a broad coalition of psychiatric and lay activists began a campaign to transform mental health policy. The initial success came in 1946 with the enactment of the National Mental Health Act. This novel law made the federal government an important participant in an arena traditionally reserved for the states. The passage of the Community Mental Health Centers Act in late 1963 (signed into law by President John F. Kennedy just prior to his death) culminated two decades of agi-

tation. The legislation provided federal subsidies for the construction of community mental health centers (CMHCs) that were intended to be the cornerstone of a radically new policy. In short, these centers were supposed to facilitate early identification of symptoms, offer preventive treatments that would both diminish the incidence of mental disorders and prevent long-term hospitalization, and provide integrated and continuous services to severely mentally ill people in the community. Ultimately, such centers would render traditional mental hospitals obsolete.

Hailed as the harbingers of a new era, CMHCs failed to live up to their promise. Admittedly, appropriations fell far below expectations because of the budgetary pressures engendered by the Vietnam War. More important, CMHCs served a population different from the one originally intended. Most centers made little effort to provide coordinated aftercare services and continuing assistance to severely and persistently mentally ill persons. They preferred to emphasize psychotherapy, an intervention especially adapted to individuals with emotional and personal problems and one that appealed to a professional constituency. Even psychiatrists in community settings tended to deal with more affluent neurotic patients rather than with severely mentally ill persons.

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Equally significant, the focus of federal policy shifted dramatically during the 1970s because of a growing perception that substance abuse (particularly drugs and, to a lesser extent, alcohol) represented major threats to the public at large. Beginning in 1968, Congress enacted legislation that sharply altered the role of the CMHCs by adding new services for substance abusers, children, and elderly persons. Congress believed that the act of 1963 had resolved most of the major problems of the mentally ill and that greater attention should be paid to other groups in need of mental health services. As the services provided by centers proliferated, the interests of the severely and persistently mentally ill—clearly the group with the most formidable problems—slowly receded into the background.

The inauguration of Richard Nixon in 1969 altered the political environment. Between 1970 and 1972, his administration worked assiduously to scale back National Institute of Mental Health (NIMH) programs, many of which survived only because of a sympathetic Congress. By 1973, however, the White House was preoccupied with the Watergate scandal, and mental health policy issues faded from view. Nixon's resignation in the summer of 1974 was welcomed by those concerned with mental health policy issues, if only because he was perceived as an opponent of any significant federal role in shaping and financing services. In the months preceding and following Nixon's resignation, Congress reassessed the CMHC program. The result was the passage of a mental health law in mid-1975 over President Gerald Ford's veto. Yet this legislation—which expanded the role of CMHCs—never addressed the fundamental issue of providing for the basic human and medical needs of the severely mentally ill.

The accession of Jimmy Carter to the presidency in 1977 introduced a new element of hope. In one of his first acts, Carter signed an executive order creating the President's Commission on Mental Health to review national needs and to make necessary recommendations. Yet the Commission's final report offered at best a potpourri of diverse and sometimes conflicting recommendations. Eventually Congress passed the Mental Health Systems Act a month before the presidential election. Its provisions were complex and in some respects contradictory. Nevertheless, the law at the very least suggested the outlines of a national system that would ensure the availability of both care and treatment in community settings.

The Mental Health Systems Act had hardly become law when its provisions became moot. The accession of Ronald Reagan to the presidency led to an immediate reversal of policy. Preoccupied with both reducing taxes and federal expenditures, the new administration proposed a 25 percent cut in federal funding. More important, it called for a conversion of funding for federal mental health programs into a single block grant to the states, a grant carrying few restrictions and without policy guidelines. The presidential juggernaut proved irresistible, and in the summer of 1981 the Omnibus Budget Reconciliation Act was signed into law. Among other things, it provided a block grant to states for mental health services and substance abuse. At the same time, it repealed most of the provisions of the Mental Health Systems Act. The new legislation did more than reduce federal funding for mental health; it reversed nearly three decades of

federal involvement and leadership. In the ensuing decade, the focus of policy and funding shifted back to the states and local communities, thus restoring in part the tradition that had prevailed until World War II. The transfer and decentralization of authority, however, exacerbated existing tensions; federal support was reduced at precisely the same time that states were confronted with massive social and economic problems that increased their fiscal burdens.

### **The Paradox of Deinstitutionalization**

Disagreements over national mental health policy were but one development that had major repercussions on mental health care. Equally significant, during and after the 1970s the states accelerated the discharge of large numbers of severely and persistently mentally ill persons from public mental hospitals. The origins of "deinstitutionalization"—a term that is both imprecise and misleading—are complex. Prior to World War II, responsibility for care and treatment had been centralized in public asylums. Under the policies adopted during and after the 1960s, however, responsibility was spread among a number of different programs and systems. The failure of CMHCs to assume the burdens previously shouldered by state hospitals, for example, magnified the significance of the medical care and entitlement systems. General hospitals with and without psychiatric wards began to play an increasingly important role in treating the mentally ill. Because such persons tended to be unemployed and thus lacked either private resources or health insurance, their psychiatric treatment was often financed by Medicaid. Similarly, responsibility for care (that is, for food, clothing, and shelter) was slowly subsumed under the jurisdiction of federal entitlement programs. A paradoxical result followed. The fragmentation of what had once been a unified approach to mental illnesses was accompanied by an expansion of resources to enable seriously mentally ill persons to reside in the community.

During and after the 1960s, deinstitutionalization was indirectly sanctioned by the judiciary when federal and state courts began to take up long-standing legal issues relating to the mentally ill. The identification of these new legal issues had significant consequences for psychiatrists and the mentally ill. The traditional preoccupation with professional needs was supplemented by a new concern with patient rights. Courts defined a right to treatment in a least-restrictive environment, shortened the duration of all forms of commitment and placed restraints on its application, undermined the sole right of psychiatrists to make

purely medical judgments about the necessity of commitment, accepted the right of patients to litigate both before and after admission to a mental institution, and even defined a right of a patient to refuse treatment under certain circumstances. The emergence of mental health law advocates tended to weaken the authority of both psychiatrists and mental hospitals and conferred added legitimacy on the belief that protracted hospitalization was somehow counterproductive and that community care and treatment represented a more desirable policy choice.

Judicial decisions, however significant, merely confirmed existing trends by providing a legal sanction for deinstitutionalization. Some knowledgeable figures recognized the danger and voiced concern. Nevertheless, the pattern of discharging patients from mental hospitals after relatively brief stays accelerated after 1970 because of the expansion of federal entitlement programs having no direct relationship with mental health policy. States began to take advantage of a series of relatively new federal initiatives that were designed to provide assistance for a variety of disabled groups and thus facilitate their maintenance in the community.

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The elderly were among the first to be affected by new federal policies. Immediately following the passage of Medicaid in 1965, states began to shift the care of elderly persons with behavioral symptoms from mental hospitals to chronic-care nursing facilities. This move was hardly the result of altruism or a belief that the interests of aged persons would be better served in such institutions. On the contrary, state officials were predisposed to the use of nursing homes because a large part of the costs were assumed by the federal government. The quality of care in such facilities (which varied in the extreme) was not an important consideration in transferring patients. Indeed, the relocation of elderly patients from mental hospitals to extended-care facilities was often marked by increases in the death rate. Moreover, many nursing homes provided no psychiatric care. When Bruce C. Vladeck

published his study of nursing homes in 1980, he selected as his book title *Unloving Care: The Nursing Home Tragedy*.

During the 1960s, the population of nursing homes rose from about 470,000 to nearly 928,000, largely as a result of Medicaid. A study by the General Accounting Office in 1977 noted that Medicaid was "one of the largest single purchasers of mental health care and the principal Federal program funding the long-term care of the mentally disabled." It also was the most significant "federally sponsored program affecting deinstitutionalization." By 1985, nursing homes had over 600,000 residents diagnosed as mentally ill; the cost of their care was over \$10.5 billion, a large proportion of which was paid for by Medicaid. The massive transfer of large numbers of elderly patients who behaved in abnormal ways was not controversial, if only because such individuals posed no obvious threats to community residents. Designed to provide services for the elderly and indigent, therefore, Medicaid (as well as Medicare) quickly became one of the largest mental health programs in the United States.

Other federal programs had an equally profound effect on the nonelderly mentally ill. In 1956, Congress had amended the Social Security Act to enable eligible persons age fifty and over to receive disability benefits. The Social Security Disability Insurance (SSDI) program continued to become more inclusive in succeeding years, and it ultimately covered the mentally disabled. In 1972 the Social Security Act was further amended to provide coverage for individuals who did not qualify for benefits. Under the provisions of Supplemental Security Income for the Aged, the Disabled, and the Blind (more popularly known as SSI), all those whose age or disability made them incapable of holding a job became eligible for income support. This entitlement program was administered and fully funded by the federal government; its affiliation with Social Security had the added virtue of minimizing the stigmatization often associated with welfare. SSI and SSDI encouraged states to discharge severely and persistently mentally ill persons from mental hospitals, since federal payments would presumably enable them to live in the community. Those who were covered under SSI also became eligible for coverage under Medicaid. In addition, public housing programs and food stamps added to the resources of mentally ill persons residing in the community.

The expansion of federal entitlement programs hastened the discharge of large numbers of institutionalized patients during and after the 1970s. This trend was reflected in the changing pattern of mental hospital

populations. In the decade following 1955, the inpatient population declined modestly, falling from 559,000 to 475,000. The decreases after 1965 were dramatic. Between 1970 and 1986 the number of inpatient beds in state and county institutions declined from 413,000 to 119,000. Length-of-stays dropped correspondingly. Yet state hospitals remained the largest provider of total inpatient days of psychiatric care; their clients were disproportionately drawn from the ranks of the most difficult, troubled, and violence-prone.

In theory, the combination of entitlement programs and access to psychiatric services outside of mental hospitals should have fostered greater state financial support for community programs. The presumption was that a successful community policy would eventually permit the consolidation of some mental hospitals and the closure of others, thus facilitating the transfer of state funds from institutional to community programs. In practice, however, the state mental hospital proved far more resilient than its critics had anticipated. Some had powerful support among community residents and employees, who feared the dramatic economic consequences that would accompany closure. A shrinking inpatient census, therefore, sometimes led to rising per capita expenditures, since operating costs were distributed among fewer patients. Equally important, there remained a seemingly irreducible group of individuals who were so disabled that institutional care appeared to be a necessity. Using data collected by the NIMH, the authors of one study concluded that there appeared "to be a core of some 100,000 residents for whom there is no alternative to state hospital treatment."

In retrospect, mental health policy changed dramatically after 1965, but not in the manner envisaged by those active in its formulation. After World War II, there was a decided effort to substitute an integrated community system of services for traditional mental hospitals. The system that emerged in the 1970s and 1980s, however, was quite different. First, mental hospitals did not become obsolete, even though they lost their central position. They continued to provide both care and treatment for the most severely disabled part of the population. Second, community mental health programs expanded dramatically, and inpatient and outpatient psychiatric services became available both in general hospitals and through CMHCs. A significant proportion of their clients, however, represented new populations that did not fall within the seriously mentally ill categories. Finally, a large part of the burden of supporting severely mentally ill persons in the community fell to a variety of federal entitlement pro-

grams that existed quite apart from the mental health care system. Since the 1970s, therefore, severely and persistently mentally ill persons have come under the jurisdiction of two quite distinct systems—entitlements and mental health—that often lacked any formal programmatic or institutional linkages.

Whatever its contradictory and tangled origins, deinstitutionalization had positive consequences for a large part of the nation's severely and persistently mentally ill population. Data from the Vermont Longitudinal Research Project offered some dramatic evidence that individuals with severe mental illness who were provided with a range of comprehensive services could live in the community. Between 1955 and 1960, a multidisciplinary team initiated a program of comprehensive rehabilitation and community placement for 269 back-ward patients who were considered to be among the most severely disabled and chronically mentally ill in the Vermont State Hospital. Middle-aged, poorly educated, and lower class, they had histories of illness that averaged sixteen years, had been hospitalized between one and ten times, and as a group, averaged six years of continuous institutionalization. More than 80 percent were single, divorced, separated, or widowed, and they were rarely visited by friends or relatives. Their disabilities were those characteristic of schizophrenics.

Initially the multidisciplinary team constructed a new inpatient program that consisted of "drug treatment, open-ward care in homelike conditions, group therapy, graded privileges, activity therapy, industrial therapy, vocational counseling, and self-help groups." In the community treatment component, the same clinical team established halfway houses and outpatient clinics, located and placed individuals in jobs, and linked patients to support networks. Periodic follow-up evaluations were conducted over the next twenty-five years. The results indicated that two-thirds "could be maintained in the community if sufficient transitional facilities and adequate aftercare was provided." These results were confirmed by similar longitudinal studies in the United States, Switzerland, and Germany. A variety of other experiments have confirmed that individuals with severe mental disorders prefer and do better in community settings that dispense economic resources (particularly vocational rehabilitation) and a kind of empowerment that provides a feeling of mastery rather than a sense of dependency.

### **The Dilemma of Young Adult Chronic Patients**

Under the best of circumstances, deinstitutionalization would have been difficult to implement. The

proliferation of programs and absence of formal integrated linkages, however, complicated the task of both clients and those responsible for providing care and treatment. Moreover, the decades of the 1970s and 1980s were hardly propitious for the development and elaboration of programs to serve disadvantaged populations such as the severely and persistently mentally ill. The dislocations and tensions engendered by the Vietnam War, the rise of antigovernment ideologies, and an economic system that no longer held out as great a promise of mobility and affluence combined to create a context that made experimentation and innovation more difficult. The founding of the National Alliance for the Mentally Ill (NAMI) in 1979 helped in part to redress the balance. It brought together families of the mentally ill in an advocacy organization that began to play an increasingly important role in the politics of mental health during and after the 1980s.

As a policy, deinstitutionalization was based on the premise that the population found in mental hospitals was relatively homogeneous. The first major wave of discharges occurred after 1965 among a group of individuals who had either been institutionalized for relatively long periods of time or who had been admitted later in their lives. This phase was not controversial, nor did it create difficulties, since few of these individuals seemed to pose a threat to others.

After 1970, a quite different situation prevailed because of basic demographic trends in the population as a whole and changes in the mental health service system. Following World War II and peaking in the 1960s, there was a sharp rise in the number of births. Between 1946 and 1960, more than fifty-nine million births were recorded. The disproportionately large size of this age cohort meant that the number of persons at risk from developing severe mental disorders was very high. Moreover, younger people tended to be highly mobile. Whereas 40 percent of the general population moved between 1975 and 1979, between 62 and 72 percent of individuals in their twenties changed residences. Like others in their age cohort, large numbers of young adult severely and persistently mentally ill persons also moved frequently both within and between cities and in and out of rural areas.

At the same time that the cohort born after 1945 was reaching their twenties and thirties, the mental health service system was undergoing fundamental changes. Prior to 1970, persons with severe and persistent mental disorders were generally cared for in state hospitals. If admitted in their youth, they often remained institutionalized for decades or were discharged and readmitted. Hence their care and treat-

ment was centralized within a specific institutional context, and in general they were not visible in the community at large. Although chronically mentally ill persons were always found in the community, their relatively small numbers posed few difficulties and in general did not arouse public concern.

After 1970, however, a subgroup of the severely mentally ill—composed largely of young adults—were adversely affected by the changes in the mental health service system. Young chronically mentally ill persons were rarely confined for extended periods within mental hospitals. Restless and mobile, they were the first generation of psychiatric patients to reach adulthood within the community. Although their disorders were not fundamentally different from those of their predecessors, they behaved in quite different ways. They tended to emulate the behavior of their age peers, who were often hostile toward conventions and authority. The young adult mentally ill exhibited aggressiveness and volatility and were noncompliant. They generally fell into the schizophrenic category, although affective disorders and borderline personalities were also present. Above all, they lacked functional and adaptive skills.

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Complicating the clinical picture were high rates of alcoholism and drug abuse among these young adult chronically mentally ill patients, which only exacerbated their volatile and noncompliant behavior. Their mobility and lack of coping skills also resulted in high rates of homelessness. Many of them traveled and lived together on the streets, thereby reinforcing each other's pathology. Virtually every community experienced the presence of these young adult chronically ill individuals on their streets, in emergency medical facilities, and in correctional institutions. Recent estimates have suggested that perhaps a quarter to a third of the single adult homeless population have a severe mental disorder. Many have a dual diagnosis of severe mental illness and substance abuse. Studies of these individuals have found that they experienced extremely harsh living conditions, were demoralized, granted "sexual favors for food and money," and were often caught up

in the criminal justice system. They had few contacts with their families, were often victimized and socially isolated, mistrusted people and institutions, and were resistant to accepting assistance. Such patients tended to arouse negative reactions from mental health professionals, if only because chronicity and substance abuse contradicted the medical dream of cure.

Deinstitutionalization was largely irrelevant to many of the young patients who were highly visible after 1970. They had little or no experiences with prolonged institutionalization and hence had not internalized the behavioral norms of a hospital community. To be sure, many of the norms of patienthood in institutions were objectionable, but at the very least they provided individuals with some kind of structure. Lacking such guidance, many young chronically mentally ill patients—especially those with a dual diagnosis—developed a common cultural identity quite at variance with the society in which they lived. The mobility of such individuals, the absence of a family support system, and programmatic shortcomings complicated their access to such basic necessities as adequate housing and social support networks. The dearth of many basic necessities of life further exacerbated their severe mental disorders. Ironically, at the very time that unified, coordinated, and integrated medical and social services were needed to deal with a new patient population, the policy of deinstitutionalization created a decentralized system that often lacked any clear focus and diffused responsibility and authority.

### **The Mentally Ill in the Community**

A superficial analysis of the mental health scene in the recent past can easily lead to depressing conclusions. The combined presence of large numbers of young adult chronically ill individuals as well as larger numbers of homeless people undoubtedly reinforced the public's feelings of apprehension and professionals' feelings of impotence. Indeed, the popular image of mental illnesses and the mental health service system was often shaped by spectacular exposés in the media—broadcast and printed—that seemed to reveal sharp and perhaps irreconcilable tensions. In these exposés could be seen the conflict between absolutist definitions of freedom and other humanitarian and ethical principles, as well as concern that the well-being, if not the very safety, of the community seemed endangered.

The image of deinstitutionalization so often portrayed in the press and on television, nevertheless, represented a gross simplification that ignored a far more

complex reality. The popular image of severely and persistently mentally ill adults, using drugs, wandering the streets of virtually every urban area, threatening residents, and resisting treatment and hospitalization, was true but represented only a portion of a much larger problem. Often overlooked were innovative programs that were specifically designed to deal with the rest of the severely and chronically mentally ill in the 1970s and 1980s.

Some of the initial results in the early 1980s with community support systems programs were encouraging. They served a chronically ill population, and those with the greatest needs were the beneficiaries. Outward appearances to the contrary, the condition of many severely and persistently ill persons improved during the remainder of the decade, as many states attempted to integrate such federal entitlement programs as SSDI, SSI, Medicaid, and Medicare with community mental health services. Nevertheless, the impact of these developments was often overshadowed by the massive problems posed by homelessness, the presence of individuals who were both severely mentally ill and substance abusers, and an angry and sometimes alienated public fearful that their security was being endangered.

A quite different perspective on community programs became evident during these years. From World War II to the 1960s, community mental health had been portrayed in terms of an all-embracing panacea; its supporters employed rhetoric and largely ignored the absence of empirical data that might validate their assertions. Exaggerated claims inevitably prepared the ground for a reaction that threatened to inhibit or undermine efforts to deal with the needs of a severely disabled population. In succeeding decades, by contrast, community care and treatment came to have a quite different meaning. The focus on cure and prevention, although still pervasive, became less significant. The emphasis shifted to the need to limit disability and to preserve function. Moreover, advocates of experimental community programs were more prone to concede that cure, independence, and total integration into normal society were often not achievable, and that many (but not all) severely and persistently mentally ill persons might require comprehensive assistance and services for much of their adult lives. In sum, the challenge was to create a system that provided all of the elements incorporated into traditional mental hospitals but without the liabilities that accompanied protracted institutionalization.

The integrated and comprehensive community programs created during and after the 1970s provided

evidence of the difficulties that lay ahead. To administer a program responsible for a variety of different patients proved a formidable undertaking, especially in view of the need to deal with multiple sources of funding. Nor was it inexpensive or easy to replicate elsewhere the results achieved in any given community. Yet at the very least such programs offered guidelines.

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Perhaps the best known of the community mental health care programs was developed in Madison, Wisconsin, by Leonard Stein, Mary Ann Test, and others. Its origins went back to the late 1960s, when efforts were made to combat the negative effects of long-term hospitalization that tended to infantilize patients and reduce them to a state of near total dependency. Although subject to debate, the results of the Madison experiment seemed to suggest that it was possible for highly impaired persons to be cared for in the community (though not necessarily at less cost than in other settings). Clinical interventions appeared to have a more beneficial impact on those in the program than on those in the control group. The former also tended to have better outcomes in terms of personal relationships, derived greater satisfaction, and had lower rates of hospitalization. Nevertheless, they remained marginalized and dependent—an indication that cure and recovery remained distant and remote possibilities.

There were a number of attempts to replicate the Madison model both in the United States and elsewhere. Most had to make significant alterations, if only because of the existence of important differences between Madison and the areas in which the model was duplicated. The most consistent finding was that assertive community care and treatment reduced hospitalization. The meaning of this finding, however, remained unclear. Were reductions in hospitalization, for example, accompanied by compensatory increases in other forms of supervision? Did such programs shift burdens to the families of patients? Until these and other questions can be answered, the relevance of the Madison experiment remains murky. Moreover, there

are fundamental differences between Madison and much larger urban areas; what was effective in the former is not necessarily applicable to the latter.

In an effort to improve services to the chronically mentally ill population, the Robert Wood Johnson Foundation—the nation's largest foundation concerned with health—created the Program on Chronic Mental Illness in 1985. Under this program, nine cities were given resources to create a central mental health authority to deliver services to chronically mentally ill persons. Preliminary findings suggested that in the nine cities selected, services were being directed toward the care of the severely and persistently mentally ill; that a central authority was more likely to be concerned with the ways in which the system as a whole was serving client needs rather than being preoccupied with individual programs; that centralization improved levels of financial support; and perhaps most important, that change was possible. Whether or not the Robert Wood Johnson Program on Chronic Mental Illness and others will succeed in redressing existing shortcomings remains an open question. "There is no quick fix for the problems that plague public mental health systems," David Mechanic conceded. "The problems are deeply entrenched and difficult to solve. Many public officials are concerned that investments in mental health will not yield significant visible benefits that justify taking political risks." Nevertheless, he insisted that the integration of different strategies—including the integration of assertive community treatment, approaches that unified diverse sources of funding and directed them toward meeting the needs of disabled persons, strong local mental health authorities, and rational reimbursement structures—offered at least the potential for improvement.

The persistence of problems, however, should not be permitted to conceal the more important fact that a large proportion of severely and persistently mentally ill persons have made a more or less successful transition to community life as a result of the expansion of federal disability and entitlement programs. To be sure, the media and the public are prone to focus on a subgroup of young adults who have a dual diagnosis of mental illness and substance abuse and who tend to be homeless. Their visibility on the streets often overshadows the inadvertent success of deinstitutionalization. "In fact," two authorities have recently written, "the situation is indeed much better for many people, and overall it is much better than it might have been. . . . While many people still do not have adequate incomes or access to the services theoretically provided through Medicaid and Medicare, the fact that

the structure exists within these federal programs to meet the needs of these individuals represents a major step forward."

### "Lessons" of History

It would be useful if knowledge of past policies could offer a sound prescription for the present and future. Unfortunately, the "lessons" of history are less than clear and are often fraught with contradictions and ambiguities. Individuals persist in selecting examples or making analogies that allegedly support their preferred policies. Yet historical knowledge can deepen the way in which we think about contemporary issues and problems; it can also sensitize us to the dangers of simplistic thinking or utopian solutions. The presumption that conscious policy decisions will lead unerringly to stipulated consequences, for example, ignores the reality that individuals and groups often adjust their behavior and reshape laws and regulations and policies in unanticipated and sometimes unwelcome ways.

The history of the care and treatment of the mentally ill in the United States for almost four centuries offers a sobering example of a cyclical pattern that has alternated between enthusiastic optimism and fatalistic pessimism. In the nineteenth century, an affinity for institutional solutions led to the creation of the asylum, an institution designed to promote recovery and to enable individuals to return to their communities. When early hospitals seemed to enjoy a measure of success, institutional care and treatment became the basis of public policy. States invested large sums in creating a public hospital system that integrated care with treatment. The adoption of this new policy reflected a widespread faith that insanity was a treatable and curable malady and that chronicity would only follow the failure to provide effective hospital treatment.

No institution ever lives up to the claims of its promoters, and the mental hospital was no exception. Plagued by a variety of problems, its reputation and image were slowly tarnished. When it became clear that hospitals were caring for large numbers of chronically ill patients, the stage was set for an attack on its legitimacy after World War II. Its detractors insisted that a community-based policy could succeed where an institutional policy had failed and that it was possible to identify mental illnesses in the early stages, at which time treatment would prevent the advent of chronicity. Between the 1940s and 1960s, there was a sustained attack on institutional care. This assault finally succeeded when Congress enacted legislation



that shifted the locus of care and treatment back to the community. But the community mental health policy proved no less problematic than its institutional predecessor. Indeed, the emergence of a new group of young chronically mentally ill persons in the 1970s and 1980s created entirely new problems, for the individuals who constituted this group proved difficult to treat and to care for under any circumstances. Yet unforeseen developments—notably the expansion of federal disability and entitlement programs—made it possible for many severely and chronically mentally ill people to live in the community.

Each of these stages was marked by unrealistic expectations and rhetorical claims that had little basis in fact. In their quest to build public support and legitimate their cherished policy, psychiatric activists invariably insisted they possessed the means to prevent and cure severe mental disorders. When such expectations proved unrealistic, they blamed either callous governments, an uninformed public, or an obsolete system that failed to incorporate the findings of medical science.

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If U.S. society is to deal effectively, compassionately, and humanely with the seriously mentally ill, we must acknowledge that this group includes individuals with quite different disorders, prognoses, and needs, the outcome of which varies considerably over time. Some schizophrenics, for example, have reasonably good outcomes; others lapse into chronicity and become progressively more disabled. We must also confront the evidence that serious mental disorders are often exacerbated by other social problems of a non-medical nature—poverty, racism, and substance abuse. Although psychiatric therapies can alleviate symptoms and permit individuals to live in the community, there is no “magic bullet” that will cure all cases of serious mental illnesses. Like cardiovascular, renal, and other chronic degenerative disorders, serious mental disorders require both therapy and management.

Serious mental illnesses can strike at any time and among all elements of the population. The ensuing

impact on the individual, family, and society is immense, for it often leads to disability and dependency. Rhetorical claims to the contrary, little is known about the etiology of serious mental disorders. Treatment—whether biological or psychosocial—does not necessarily eliminate the disorder. The absence of curative therapies, however, ought not to be an occasion to disparage efforts to find ways to alleviate some of the adverse consequences of illness. Many therapies assist seriously ill persons in coping with and managing their condition. “In the last analysis,” a group of investigators recently concluded, “systems of treatment are not as yet able to cure, but they should be able to remove the obstacles that stand in the way of natural self-healing processes.”

For too long mental health policies have embodied an elusive dream of magical cures that would eliminate age-old maladies. Psychiatrists and other professionals have justified their *raison d’être* in terms of cure and overstated their ability to intervene effectively. The public and their elected representatives often accepted without question the illusory belief that good health is always attainable and purchasable. The result has been periods of prolonged disillusionment that have sometimes led to the abandonment of severely incapacitated persons. Public policy has thus been shaped by exaggerated claims and by unrealistic evaluative standards. Largely overlooked or forgotten are ethical and moral considerations. All societies, after all, have an obligation toward individuals whose disability leads to partial or full dependency. Even if the means of complete cure are beyond our grasp, it does not follow that we ought to ignore those whose illness incapacitates them. To posit an absolute standard of cure leads to a paralyzing incapacity to act in spite of evidence that programs that integrate mental health services, entitlements, housing, and social supports often minimize the need for prolonged hospitalization and foster a better quality of life. It has often been noted that a society will be judged by the manner in which it treats its most vulnerable and dependent citizens. In this sense, the severely mentally ill have a moral claim upon our sympathy, upon our compassion, and above all, upon our assistance.

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