

# **MENTAL HEALTH POLICY IN THE UNITED STATES: FROM INSTITUTIONS TO COMMUNITY MENTAL HEALTH**

By

**Michael B. Friedman, LMSW  
Adjunct Associate Professor  
Columbia University School of Social Work**

Abstract: This lecture provides a brief historical overview of mental health policy in the United States from Colonial times, prior to the emergence of a concept of mental illness, to the development of psychiatric institutions at the end of the 18<sup>th</sup> century to the development of a community-based mental health system in the middle of the 20<sup>th</sup> century. This account focuses on critical lessons from history for understanding and improving America's current mental health system.

The American mental health system unquestionably needs vast improvement. That's easier said than done.<sup>1</sup> And I believe that it is critical to know the history of mental health policy to be able to make changes that may actually result in improvement.

The purposes of this lecture are (1) to provide a brief historical overview of mental health policy in the United States from Colonial times, prior to the emergence of a concept of mental illness, to the development of psychiatric institutions to the transition to a community-based system and (2) to use the history to reveal critical lessons for understanding and improving the current mental health system.

## **The Origins of Mental Health Policy in America**

In its origins in Colonial America, mental health policy was not about mental **health**, which was a concept that did not yet exist. Nor was it about mental **illness**, which was mostly a foreign concept that would not take root in America until the end of the 18<sup>th</sup> century. No, mental health policy originally was about how to deal with madness or "lunacy", as it was often called. It was about how to help afflicted people to survive and about how to manage them when their behavior was difficult or dangerous. One way to think of this is that **in its origins mental health policy was a branch of social welfare policy and of criminal justice policy.**

Historically, mental health policy is best understood as an amalgam of social welfare, criminal justice, and health policy rather than as a subset of health policy.

Also, in its origins mental health policy focused on a much narrower population than it does today. According to current psychiatric epidemiology, about ¼ of us has a diagnosable mental and/or substance use disorder in any given year,

½ in our lifetimes.<sup>2</sup> But these numbers reflect a vast expansion of the concept of mental illness that took place during the 20<sup>th</sup> century. Historically, most personal and emotional problems were thought of as eccentricities or oddities, character flaws, or just ordinary worry and sadness, but not as illness. In today's parlance, the population that was the focus of mental health policy until **the mid-20<sup>th</sup> century were people with "severe and persistent mental illness" or long-term "psychiatric disabilities". This is at most 1-3% of the adult population of the U.S., not 25%.**

Whether the concept of mental illness has become too broad is a matter of debate. Should public policy focus inclusively on the full range of people with diagnosable mental disorders or should it focus primarily on those disabled by mental illness?

### **Dreadful Treatment in Colonial America**

In accordance with the Poor Laws, which the English settlers brought with them to their new home, care for "lunatics" during Colonial times was the responsibility of families and local communities.

Local communities dealt with lunatics who did not have families to take care of them in a variety of ways, including paying people to provide care in their homes, "renting" them to local farmers, putting them in poorhouses, putting them (often chaining them) in jails when their behavior was a problem, or taking them to the edge of town and "whipping them out" when the community decided it had had enough.

Poorhouses and workhouses were designed for mere subsistence so as to avoid creating an incentive for poor people to choose welfare over work.

Jails and prisons were unsanitary and dangerous. For example, there is a replica of the jail in Williamsburg, VA, which was used to hold people with serious mental illness along with criminals before the creation of the Virginia Hospital. It is essentially a large outhouse in which as many as twenty people lived. Imagine how terrible the stench must have been and how many people must have died from contagious diseases. The chains that were used to restrain disturbed prisoners are still on the walls.

### **Hospitals and Asylums**

Towards the end of the 18<sup>th</sup> century, the concept of mental illness made a significant appearance in America, and hospitals serving people with mental illness were created. The first state hospital exclusively for this population was in Virginia. The Pennsylvania Hospital in Philadelphia was the first to have what we would now call a psychiatric unit.

The hospital in Virginia was based on the philosophy of “*traitement morale*” (best translated “humane” treatment), which was developed in France by Phillippe Pinel. It stressed kindness and engagement in activities for people with severe mental illnesses and bore striking similarities to what we call psychiatric rehabilitation today.

Humane attitudes about madness contributed to further development of hospitals and asylums for “lunatics” during the 19<sup>th</sup> century. The growth of these institutions also reflected a trend in the U.S. to create separate institutions for different populations rather than to house dependent people all together in poorhouses. For example, orphanages and old age homes emerged to separate children and the infirm elderly from working age adults. Similarly, asylums were created to provide protection for people with mental disabilities—both psychological and developmental— “lunatics” and “idiots” in the parlance of that era.

Dorothea Dix,<sup>3</sup> the major advocate for these asylums in the U.S., campaigned for them to be state-run rather than local. She also campaigned for the use of federal lands as locations for asylums. In the decade before the Civil War, Congress agreed; but Franklin Pierce vetoed the measure, setting a precedent regarding the federal role in mental health that to some extent remains in place today.

**The federal, state, and local levels of government have different responsibilities for people with mental illness, and these responsibilities shift over time.** The advent of state asylums in the 19<sup>th</sup> century shifted much responsibility from local to state governments, but not to the federal government. This changed in the mid-20<sup>th</sup> century, but to a limited extent. The appropriate role of the federal government is still a matter of major debate.

## **Custodial Care**

Sadly, conditions in asylums deteriorated dreadfully during and after the Civil War when it was not economically feasible to provide good care in decent facilities. They became incredibly overcrowded and understaffed.

**Historically, quality of care for people with mental illness varies with the economy.** It has been at its worst in periods like the Civil War and the subsequent depression as well as during the Great Depression in the 1930s and World War II.

Simultaneously, a pessimistic view of the effectiveness of treatment became widespread, and during this period, **custodial care, rather than treatment and recovery, became the primary goal of asylums.**

The shift to the view that the purpose of asylums was to provide subsistence level care rather than to provide treatment—ineffective as it was in those days—set the stage for over a century of poor—often abusive—care in state hospitals and asylums. Even interventions that were supposed to be helpful often verged on torture. For example, restraints used when patients were out of control were frequently dangerous, sometimes cruel, and could cause injuries or even deaths. Chains, straight jackets, and solitary confinement (known as “isolation”) were commonplace. One particularly horrible form of restraint is on display at the hospital exhibit in Williamsburg, Virginia—a coffin with a wire mesh cover nailed over patients until they were “ready” to be removed. Imagine the anxiety induced by such a confrontation with death.

In addition, interventions called “treatment” often were needlessly painful and punitive with no real benefit. Also on display in Williamsburg is a so-called “treatment chair” that was sometimes used in the 19<sup>th</sup> century to calm agitated patients. It resembled an electric chair, with a high back and wide arms, but it had a hole in the seat with a pot underneath. Patients were strapped in naked and had ice water poured over them until they “chilled out” as we might say today. No one could control their bladders or bowels during such “treatment”. Thus, the hole in the seat. Imagine the humiliation as well as the pain.

**Historically, terribly harmful treatments have been tried and abandoned despite great, initial optimism about their effectiveness.** In the 20<sup>th</sup> century this included insulin shock treatment and psychosurgery. Electric shock treatment (ECT) also did considerable harm to patients when it was first developed, although it has been refined over the years and is now, arguably, safe and sometimes effective, albeit a treatment of last resort. **There may very well be some “treatment” we are currently providing that will—in hindsight—turn out have done more harm than good.**

### **Race And Hospitals and Asylums**

During the first half of the 19<sup>th</sup> century, when hospitals and asylums for people with psychiatric disabilities were developed in the United States, Black slaves were a substantial portion of the population of southern states and free Blacks were a smaller portion of the population of Northern states. After the Civil War, former slaves were in theory free but continued to suffer from severe racial discrimination. Standard histories of the treatment of people with mental illness in the United States pay scant attention to this.

For the most part, treatment of Blacks by hospitals and asylums reflected the racist beliefs and structures of the American society at that time. Integration of Blacks and Whites in these institutions was rare. Many states

made no provisions for Blacks with severe mental illness at all. They were simply excluded from state institutions. In other states there were separate facilities or segregated units for Blacks—separate and unequal, as was the case for most institutions in the United States. It's dreadful but not surprising, I suppose, that the segregation of facilities for people with severe mental illness and for those with what we now call "developmental disabilities" continued until the 1960s, when it was outlawed by a court decision and then by the Civil Rights Act of 1964.

In addition, medical "experts" on "lunacy" in the 19<sup>th</sup> century by and large lent their support to slavery as the natural state of Blacks and to various theories of Black inferiority. For example, it was widely believed, with "empirical" support from fallacious census findings in 1840, that slavery protected Blacks from insanity and that living in freedom created great psychological risks for them. And some medical experts believed that a Black person's desire for freedom was a mental illness, which they called "drapetomania", from the Latin word for fugitive. These beliefs shifted to some extent after the Civil War, but widespread belief among psychiatrists that biological differences between the races had extensive impact on mental capability and stability continued long into the 20<sup>th</sup> century.<sup>4</sup>

Racism has a long and shameful history in the American mental health system and is still reflected in some of the fundamental structures of the system.

The incorporation of prevailing societal prejudices into the "empirical" views of mental health professionals has affected treatment not only of Blacks, but also of various immigrant populations, people with non-traditional lifestyles, LGBTQ, etc. It is likely that there are views we currently hold that are based more on prevailing social mythology than on sound empirical findings.

## **Reform**

During the 19<sup>th</sup> century there were several exposés about terrible conditions in state asylums. Nevertheless, by the end of the 19<sup>th</sup> century the fundamental mental health policy of the United States remained the provision of custodial care, with some "treatment", in state run institutions.

In the first decade of the 20<sup>th</sup> century, Clifford Beers founded the mental hygiene movement by publicizing the scandalous conditions of psychiatric hospitals. He had spent 3 years in psychiatric hospitals where he was miserably treated. He documented his experiences in a brilliant book entitled *A Mind That Found Itself*.<sup>5</sup> While in 3 different hospitals, Beers developed a grandiose vision to create a national and perhaps international movement to prevent abuse in hospitals and to prevent the need for hospitalization through community education and the development of

alternative sources of treatment in the community. Remarkably, he succeeded in establishing the movement, which still exists.<sup>6</sup> In some places, it is now known as Mental Health America, in other places—such as Maryland and New York State—as the Mental Health Association.

Beers and The Mental Hygiene Society had some notable successes, such as designing a system of mental health care for the military during WWI and creating a child mental health movement later in the century. But scandalous conditions in state hospitals characterized by neglect, abuse, exploitation, and excessive use of physical restraints continued. In fact, they got even worse during the Great Depression and during WWII.

Conscientious objectors who refused induction into the armed forces in WWII were often assigned to work in state psychiatric hospitals as a kind of punishment. They formed an advocacy group that documented and protested the conditions in these institutions. Later they joined with the Mental Hygiene Society to create the National Mental Health Association.

**And to remind us about horrible abuses and to create a symbol for the cause of freedom for people with mental illness, MHA created a bell modeled on the Liberty Bell, forging it from shackles and chains that had been used to restrain patients in State Hospitals.**

### **Precursors Of Community Mental Health**

Shortly after the end of WWII, advocacy for change gathered momentum, and in the mid-50's American mental health policy began to shift from institution-based to community-based.<sup>7,8,9,10,11</sup>

**Scandalous conditions in State hospitals** were, of course, a major driving force of change. But there was much more.

For example, during WWII an eighth of the men drafted for service were rejected for psychological reasons. Although it seems unlikely that so many men were really disabled by mental illness, the experience of the draft and the number of men who returned with "battle fatigue" made it clear that the prevalence of mental illness was far greater than previously believed. Clearly, **providing institutional care to less than 1/2 % of the adult population\* was an inadequate response to the needs of the much larger portion of the population whose conditions were severe**

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\* At its peak in 1955, when the population of the United States was about 150 million, there were 550,000 adults living in state hospitals. About 1/3 of them were elderly and suffered from organic brain conditions.

**enough to keep them out of the military.**

In addition, several studies revealed that **living in an institution has disabling consequences due to the nature of institutional life.** Forced separation from family and friends, the loss of normal roles, and “2<sup>nd</sup> class citizenship” of inmates often resulted in increased dependency and reduced competence. For example, Ernest Gruenberg, speaking for a group of mental health professionals, pointed to what they called “social breakdown syndrome”, a secondary form of mental illness that developed in addition to the condition that led to institutionalization in the first place.<sup>12</sup> A few years later, Erving Goffman documented the depersonalizing impact of life in total institutions in a brilliant book entitled *Asylums*.<sup>13</sup>

Psychiatric theory during the 1950s and 60s also contributed to the shift from institution to community-based mental health policy. Psychoanalytic ideas, which were dominant at that time, included the belief in environmental causes of mental illness, belief that prevention was possible if these environmental causes were addressed, and belief that mental illness exists on a continuum such that treating “neurotic” conditions would prevent the development of psychotic conditions. These views supported the **expectation that keeping people out of institutions and providing psychotherapy would prevent the development of severe mental illness and help those with it to recover.**

At the same time, **psychotropic medications were discovered** and put into widespread use in state hospitals, with great hope that quelling the more acute symptoms of psychosis would enable people to leave the hospital or avoid hospitalization and live independently in the community—if they continued to take medication.

The psychoanalytic perspective of the time combined with **unrealistic hopes for the outcome of psychotropic medications** led to a vision of people with mental illnesses living freely in the community, of responsive and caring treatment, and of prevention.

Policy changes in other arenas had tremendous impact on the shift from institution-based to community-based mental health policy. For example, **the civil rights movement inspired a similar campaign to protect the rights of people in institutions.** Lawyers representing people in state hospitals used the principle of *habeas corpus* to get people out of hospitals unless they were dangerous to self or others. There were also “right-to-treatment” cases that moved in the direction of requiring states to provide meaningful treatment if they detained a mentally ill person in need of treatment against his/her will. Other rulings limited the authority of states to involuntarily commit people with mental illness to psychiatric hospitals if they could live in the community independently or with the help of families

and friends. Another ruling outlawed work by patients in mental institutions.\*

Taken together these rulings established the rights of people with mental illness to live in the “least restrictive setting”, to have choice regarding treatment, and to be free from abuse and exploitation.

In addition, **changes in social welfare policy** had great impact.<sup>14</sup> Social Security Disability Income (SSDI) was added in the 1950s making it possible for non-dangerous people with mental illness to live in the community even though they were unable to work for a living. In the early 1970s, after deinstitutionalization was well underway, the establishment of Supplemental Security Income (SSI) shifted some, but not all, of the responsibility to provide income for people with psychiatric disabilities from the states to the federal government. This was a great benefit in states that had underdeveloped welfare programs, but of arguable benefit in states like New York, which already had a comparatively generous and intelligent welfare program.

Overall, it may well be that **the advent of social welfare benefits for people with disabilities was the most positive policy development for people with psychiatric disabilities.**

The **advent of Medicaid and Medicare in 1965** also had great impact because they provided federal funding for treatment of mental disorders in the community. Medicaid included an incentive for the states to care for people in the community rather than in institutions via a provision, known as the “IMD exclusion”, which barred federal Medicaid funding for people in “Institutions for the Mentally Diseased”. In part, the purpose of this provision was to create an incentive to reduce the census of state hospitals, but it was also put in place to hold down federal expenses. And it reflected a Constitutional principle regarding the limits of federal responsibility for people with severe mental illness, an extension of the Pierce veto that had barred the use of federal lands for state institutions a century earlier.

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\* People today are sometimes bewildered by this because having something productive to do is clearly beneficial to one’s mental health. But historically, patients were exploited. It has been estimated that as much as half of the work in institutions was done by patients including facility maintenance and being servants to staff leadership—cooks, maids, baby-sitters, chauffeurs, etc. The comparison to life on a plantation was frequently and not inappropriately used by those fighting for the civil rights of institutionalized patients.

**Medicaid also covered care in skilled nursing facilities** (nursing homes). And, because about 30% of the residents of state hospitals were older adults with organic brain disorders (dementia), the availability of Medicaid created an incentive to move patients from state hospitals to nursing homes. This came to be known as “transinstitutionalization.”

Transinstitutionalization illustrates the ineluctable fact that **decisions about how to fund services create incentives for policy decisions that may or may not contribute to the well-being of the populations being served.**

Over the years, **state and federal governments have each struggled to avoid financial responsibility for people with serious mental illness.** States have tried to shift costs to the federal government, which has generally resisted, although federal funding now exceeds state and local funding.

The mix of moral, clinical, and social thought noted above led to the vast shift in mental health policy that took place beginning in the mid-1950s. But **the shift would not have taken place without the political consensus that emerged among advocates, civil rights lawyers, community providers, academics, and researchers to replace an institution-based system with a community-based system.** Unions representing state workers objected, of course, but the balance of power was held by the other interest groups, which were able to agree on an agenda that gave each of them something. The reduction of state hospitals led to a need for more and more mental health services in the community, which community-based general hospitals and other providers favored. Academics understood that more service required more providers who would have to be trained, so more work for them. And researchers were needed to develop effective practices. It was **a powerful alliance, which—unfortunately—has been largely lost.**

**Significant changes in public policy require building alliances** with enough political power to overcome political opposition. This generally means that there must be something in it for everyone in the alliance. **Moral fervor is rarely adequate to carry the day.**

### **Deinstitutionalization**

The first phase of the transition to community-based mental health policy was called “deinstitutionalization”. Its primary goal was to reduce the

population of state hospitals, which peaked at 550,000 in 1955\* (1) by rapidly discharging patients who had been in state hospitals for a very long time, some for decades, (2) by reducing lengths of stay, and (3) by limiting admissions, aka “admission diversion.” \*\*

From the beginning, the concept of deinstitutionalization included services and supports that people with serious and persistent mental illness would need to sustain themselves in the community—including both treatment services and welfare benefits to cover housing, food, and other basics.

For example, the first major federal initiative to advance deinstitutionalization, enacted just before the assassination of President Kennedy, was called the Community Mental Health Centers Act. The thrust of this legislation was both to encourage states to reduce hospital census and to provide federal support for construction and initial operating costs for community mental health centers (CMHCs).

**CMHCs were conceptualized as providers of a comprehensive continuum of services offering continuity of care for defined geographic communities, known as catchment areas.** They were required to provide a minimum of five types of service—crisis, outpatient, inpatient (in local facilities), partial hospitalization (including day hospitals and hospitalization only at night), and community education (with the hope of preventing serious mental illness.)

### **The Inadequacies of Deinstitutionalization**

CMHCs were greeted with enthusiasm. Now we know that the ideas behind them were flawed. **Federal funding was inadequate**—structured to diminish year by year until states had full financial responsibility once again. **Continuity of care is very hard to achieve. CMHCs did not provide housing, rehabilitation, or medical care. Community education could not prevent serious mental illness.** Etc.

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\* At that rate over 1.1 million people would be in state hospitals today. Instead, there are under 40,000. Advocates for a return to reliance on institutions to care for people with mental illness usually call for an additional 100,000 beds, which in fact would not be close to the rate of institutionalization in the mid-1950s and would cost \$20 - \$30 billion per year.

\*\* Although admissions to some state hospitals may have increased during deinstitutionalization depending on local circumstances, lengths of stay were shorter and shorter; and, in general, admission to state hospitals became more and more difficult. In some areas—such as New York City, bed reduction in state hospitals resulted in huge backlogs of patients in general hospitals.

In addition, most **CMHCs became places that provided treatment for people with less severe mental disorders**. This happened in part because of the belief that treatment of neurosis would prevent the development of psychosis (later discovered to be false) and in part because the CMHCs were staffed by mental health professionals who had trained to be psychotherapists, a form of intervention that is helpful to neurotic people but is of little curative value for people with serious and persistent mental illness.

The outcome was that CMHCs fell far short of expectations. **Fewer than half of the CMHCs originally planned were ever built**; and, as useful as many were for people with less severe mental disorders, most, with notable exceptions such as the CMHC in Dane County, Wisconsin, were not particularly useful for people with serious psychiatric disabilities.

In part due to the inadequacy of federal action, many states independently pushed ahead with deinstitutionalization. They were driven to do this in part by ideology—the belief that life would be better for people with serious and persistent mental illness in the community than in an institution. But they were also driven by financial considerations. They expected costs to be less in the community than in the hospital and that savings from reducing the size and number of hospitals would “follow the patients” into the community. In addition, the incentive created by Medicaid through the IMD exclusion had a significant impact on state policy.

Beginning in about 1968, the states began to pursue deinstitutionalization very aggressively. New York State—which passed the nation’s first community mental health act in 1954—is a good example. The census of its state hospitals had declined from 93,000 to about 83,000 between 1955 and 1968, a rate of under 1000 per year. Between 1968 and 1973 the census declined to about 44,000 patients, a rate of nearly 8,000 patients per year.

But **the money did not follow the patients**. Some argue that the unions representing the state workforce used their political power to hold onto positions in hospitals that should have been moved to the community. Others, I among them, argue that the quality of care in state hospitals was abysmal and that it was critical to retain staff to try to improve quality—which in fact happened, though very, very gradually.

In general, **expectations of savings prove to be elusive**. For example, Dorothea Dix argued that shifting from poorhouses to asylums would save money. Later advocates argued that shifting from asylums to the community would result in savings. In fact, the costs of mental health services have risen, in part because of increased numbers of people served, in part because of expansion of community-based services, and in part because of the cost of improvements in quality.

Due to limited funding for community services as well as a shortage of qualified personnel, there were **few state after-care programs**, and they were mostly of poor quality. There was a particularly acute shortage of psychiatrists, especially English-speaking psychiatrists.

In addition to a shortage of decent clinical services in the community (1) for people leaving hospitals, some after thirty years or more, and (2) for people with psychotic conditions being kept out of hospitals despite acute need, **no special housing** was available.

In NYC, for example, people being discharged from hospitals, who were not returning to family or going to adult or nursing homes, generally were sent to welfare offices, which helped them to find affordable places to live—among the very poor, often in single room occupancy hotels (SROs). Amazingly almost everyone was housed, but their **living conditions were generally squalid and often dangerous**. Assaults and even murders were not rare events.

But few of those deinstitutionalized became homeless during the first decade of aggressive deinstitutionalization. Homelessness emerged later, when slum areas of the city were gentrified and **low-income housing became increasingly scarce**.

**Homelessness was also driven** by the decision of the Reagan administration to apply **stricter criteria for Social Security Disability Insurance (SSDI)**. 10's of thousands of people lost their benefits, and many more were denied eligibility. These people could no longer afford housing even in parts of the country where low income housing was available.

It is critical to understand that homelessness was not caused directly by deinstitutionalization but by the loss of low-income housing and of public income supports as well as by the lack of adequate community-based services.

During the early years of aggressive deinstitutionalization, **most patients were discharged to the care of their families**, who were overburdened and got virtually no help. This fueled the later development of the family support movement—especially the National Alliance on Mental Illness (NAMI), which has become one of the most influential advocacy organizations in the United States. **The need for family support remains critical today**.

In addition, many people were **discharged to nursing homes and to homes for adults**.<sup>\*</sup> Some of this was appropriate because a very large number of state hospital patients (about 30%) were elderly, disabled people with dementia and other organic brain conditions. But **many placements in nursing homes and adult homes were inappropriate**. Over time the conditions in adult homes especially led to **repeated scandals about neglect and exploitation of people with severe mental illness**.

As previously noted, the movement of people from state hospitals to nursing and adult homes is known as “**transinstitutionalization**”. It reflects the fact that State hospital personnel were under great pressure to empty beds and to hold down costs. Moving patients out of state hospitals to nursing and adult homes not only reduced census in state hospitals but also took related costs out of states’ mental health budgets, creating an illusion of cost savings. And nursing homes were Medicaid funded so that states got federal financial support.

Transinstitutionalization continues to be one of the major failures of community mental health policy. Assuring the appropriate use of nursing and adult homes is still a critical challenge. Even more important is the scandalously large number of people with serious mental illness inappropriately incarcerated in jails and prisons.

**Poor discharge planning** was another great failure of deinstitutionalization. It was in some ways unavoidable because there were so few decent resources in the community and hospital personnel were under great pressure to get people out. But it resulted in very poor quality of life for a great many former patients.

**Whether living in poverty in the community is worse than life in the hospital is a matter of active debate today**. Some argue that asylums were grim and dangerous and that, for the most part, life in the community is better. Others argue that some people with serious mental illness would be better off in long-term hospitalization than in jails or prisons or homeless on the streets or in shelters.

Despite the debate about whether more people should be in hospitals, there is widespread agreement that deinstitutionalization was a failure. I do not believe that this is a totally fair judgment. A great many people who were in state hospitals should never have been there or should have left much sooner. Some of them needed a different form of care related to dementia;

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<sup>\*</sup> Adult homes are residences for adults and frail elderly who are poor, cannot safely live independently or with family, and do not meet the criteria for nursing home admission.

some of them could live decently in the community once they were free to do so.

But it is true that a great many people who were discharged from state hospitals, or never admitted despite severe mental illness, fared very badly. They became the new scandal, replacing occasional revelations about the dreadful conditions of state hospitals. And **after several faltering attempts to rectify some of the problems engendered by deinstitutionalization, a new approach to community mental health known as the Community Support Program (CSP) emerged** in the late 1970s. I explore this program in the next lecture.

<sup>1</sup> Friedman, M. (2015), "The Complexity of American Mental Health Policy: Implications for Systems Improvement," *American Journal of Medical Research* 2(2): 170–181.

<sup>2</sup> Kessler, R, et al (2005). "[Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication \(NCS-R\)](#)" in *Archives of General Psychiatry*, June 2005.

<sup>3</sup> Sharfstein, S. (2022). "Dorothea Dix: A Reformer For The Ages" in [The Maryland Psychiatrist](#), May 2022.

<sup>4</sup> Geller, J (2021) 9 Essays on the history of structural racism in psychiatry.

- [Structural Racism in American Psychiatry and APA: Part 1 | Psychiatric News \(psychiatryonline.org\)](#)
- [Structural Racism in American Psychiatry and APA: Part 2 | Psychiatric News \(psychiatryonline.org\)](#)
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<sup>5</sup> Beers, Clifford (1907). *A Mind That Found Itself: An Autobiography*. University of Pittsburgh Press.

<sup>6</sup> Friedman, M. (2002). "The Clifford Beers Story: The Origins of Modern Mental Health Policy" in *Mental Health News*, Fall 2002.

<sup>7</sup> Mechanic, D. et al (2014). "A Brief History of Mental Health Policy in the United States" Chapter 3 of *Mental Health and Social Policy: Beyond Managed Care (Sixth Edition)*. PEARSON PUBLISHING

<sup>8</sup> Grob, G. (1991). *From Asylums To The Community: Mental Health Policy in Modern America*. Princeton University Press.

<sup>9</sup> Grob, G. (1994). *The Mad Among Us: A History of the Care of America's Mentally Ill*. The Free Press.

<sup>10</sup> Rochefort, D. (1997). *From Poorhouses To Homelessness: Policy Analysis and Mental Health Care*. Auburn House.

<sup>11</sup> Ridenour, N. (1961). *Mental Health in the United States: A Fifty-Year History*. Harvard University Press.

<sup>12</sup> Gruenberg, E., et al (1972). "Social Breakdown Syndrome: Environmental and Host Factors Associated with Chronicity" in *American Journal of Public Health*, January 1972.

<sup>13</sup> Goffman, E. (1961). *Asylums: Essays On the Social Situation Of Mental Patients And Oher Inmates*. Doubleday Anchor.

<sup>14</sup> Frank, R. and Glied, S. (2006). *Better But Not Well: Mental Health Policy in the United States Since 1950*. Johns Hopkins University Press.