Trends in the Development of Psychiatric Services, 1844–1994

James W. Thompson, M.D., M.P.H.

Over the past 150 years, support for providing appropriate services for mentally ill persons has waxed and waned. In colonial America, mentally ill persons were institutionalized in jails or almshouses. In the 18th and 19th centuries, asylums constituted the primary psychiatric service. Only in the late 19th and early 20th centuries did alternatives to long-term hospitalization appear. The mental hygiene movement of the early 20th century and the community mental health centers movement of the 1960s and 1970s both increased the number of services and introduced new types of services. Today, however, despite hopeful signs of reduced public prejudice against mentally ill persons, a new "dark age" for support of psychiatric services may be dawning, as negative attitudes about mental illness continue to drive public policy.

Dr. Thompson is associate professor at the Center for Mental Health Services Research of the department of psychiatry at the University of Maryland School of Medicine, 645 West Redwood Street, Baltimore, Maryland 21201. This paper is part of a special issue on the history of American psychiatry, published in observance of the American Psychiatric Association's 150th anniversary.

The 150 years since the founding of the American Psychiatric Association in 1844 have seen enormous progress in the development of psychiatric services in the United States. From an era of large institutions to the present era, with a myriad of treatment approaches, devising services for and advocating for people with mental illness have been key goals of American psychiatry. This progress, however, has been interspersed with periods of pessimism and retrenchment. Today services for people with mental disorders are again threatened by forces that play on ancient themes of misconception and fear about mental disorder, cloaked in the more socially acceptable garb of "cost-efficiency" and "managed care."

This paper provides a brief, and necessarily noncomprehensive, review of the waxing and waning of progress toward ensuring appropriate and accessible psychiatric services for mentally ill persons in the United States. Changing patterns of support for psychiatric services in the U.S. since 1844 are examined, and current services and future prospects are discussed in light of this history.

In this paper, the term "psychiatric services" designates approaches and settings that are intended to ameliorate the effects of mental illness. The term is used to describe overall approaches to treatment, such as psychosocial rehabilitation, and settings in which care is delivered, such as inpatient or outpatient facilities. It is not intended to focus on individual treatment modalities, such as pharmacotherapy, or ways in which care is organized, such as health maintenance organizations.

Services before 1844

Numerous reports indicate that many persons in colonial America, like Europeans of that period, believed mentally ill persons to be possessed by the devil. Prayer and cajoling, but also threats and physical punishment, were used to drive the devil out. The witch trials in Salem, Massachusetts, in the late 17th century were an extreme example of these efforts; they involved mentally ill persons as victims as well as accusers. However, such beliefs and practices existed well into the 18th century (1–3).

Grob (4) disagreed with the view that a belief in the demoniacal possession of persons with mental illness was the prevailing attitude in the colonies. All researchers agree, however, that little medical treatment and no organized services for mentally ill individuals existed during this period. In the few instances when mental disorder was considered to be a medical problem, the underlying cause was regarded as excessive bile or disordered blood vessels. As was the case for all illnesses, venesection (that is, bleeding), purging, and blistering were seen as the proper treatments (1).

Some efforts were made during colonial times to provide true services to mentally ill patients. For example, Dr. Thomas Kittredge boarded out patients with a few families in Andover, Massachusetts (1). However, most mentally ill persons were kept at home, often in a locked room, were jailed if they were violent or troublesome, or were treated as paupers if they were seen as harmless. Many mentally ill individuals were inmates in almshouses, publicly fi-

nanced homes for the poor, which were in general use by the 18th century (1,4–6).

The diverse American Indian groups who inhabited North America before the Europeans arrived had very different ways of dealing with persons who were mentally ill, but in general, like their European conquerors, they did not see mental illness as separate from physical illness and spiritual difficulties. However, instead of punishing or killing the afflicted person to drive out the devil, Indian people concentrated on restoring health through rituals and prayers performed by medicine men and women. These ceremonies were the first "psychiatric" services delivered on this continent by persons identified as healers (7,8).

The era of moral treatment

The history of psychiatric services from colonial times until the 20th century largely consists of the history of hospitals. The Pennsylvania Hospital, the first general hospital in America, was founded by the Quakers in 1752. Mentally ill patients were treated there, although the treatments they received were the same as those received by patients with somatic illness. When patients were unruly, handcuffs, ankle irons, and the "madd-shirt," a strait-waistcoat, were used. Overall, however, hospital authorities were motivated by kindness, rather than by the desire to punish patients (1,3).

In 1783 Dr. Benjamin Rush joined the staff of the Pennsylvania Hospital. Rush shared many of the beliefs about treatment common to his era. He supported use of mechanical restraints and corporal punishment and endorsed bleeding as a treatment. However, he also improved the hospital setting by adding heating and ventilation to hospital wards; separating violent patients from those who were less violent; adding work, exercise, and amusements to the patients' daily routine; hiring better-trained staff; and excluding visitors who might disturb the patients (1,9–11).

The first American asylum exclusively for mentally ill patients opened at Williamsburg, Virginia, in 1773. In 1817 the second institution totally for mentally ill patients—the American Friends' Asylum—was established north of Philadelphia by the Quakers (3), using principles of moral treatment that were articulated by William Tuke in England (12,13). The hospital used no chains or other extreme forms of restraint, and violent patients were segregated on a separate floor. Other hospitals in the United States that were influenced by Tuke's ideas included the Bloomingdale Asylum in New York City, founded in 1821, and the McLean Asylum of Massachusetts in Boston, opened in 1818 (1).

The asylums were held in great regard, and the expectation that they could cure mental illness was very high. Enough cases of "cure" were reported by the asylums to undermine the idea that all insane persons were incurable, although claims for success were wildly exaggerated by many asylum superintendents (13). This "cult of curability" was at a fever pitch when the forerunner of the American Psychiatric Association was formed in 1844 (1,13). Dr. Pliny Earle and other early leaders of the association were key figures in showing that the cult of curability was a sham (1).

The era of the asylums

Even in the 20th century, some persons have viewed the original asylums as a victory of reason over unreason [Foucault (14), quoted by Rothman (6)]. Although the asylums did improve the care of mentally ill patients, few patients were fortunate enough to be treated there. Early in the 19th century, most indigent mentally ill persons in the U.S. were still totally neglected. Many paupers, including the insane, were annually "sold" at auction to the lowest bidder, who then put them to work for the year (1).

In 1841, after seeing the squalid conditions in which the insane were kept at the jail in East Cambridge, Massachusetts, Dorothea Dix began a widespread movement to improve services to this population (5,15). By 1880 her crusade had resulted in the construction of 32 hospitals in several states to care for the indigent insane. The hospitals provided little true treatment but did offer an empathic atmosphere for an increasing number of mentally ill persons.

During this period, institutionalization itself began to be seen as the appropriate "treatment" for mental illness. Psychiatrists and others endorsed the view that mentally ill patients could be cured nowhere else but in the asylum and that they would be cured simply by being in the asylum (16).

However, the high hopes were dashed, as the hospitals became "mere places of custody instead of cure," and optimism about mentally ill persons' potential for improvement again turned to despair (1,16). In the late 19th century, mental hospitals began to grow enormously, with some caring for 3,000 patients. The population of patients with chronic conditions in the hospitals began to increase and to take up more and more staff time (4). Personal attention to patients became impossible, and the hospitals became primarily custodial institutions, like the almshouses they had been created to replace.

Between 1850 and 1875, several former patients wrote exposés describing conditions in the hospitals, and these works spurred the passage of laws protecting patients' rights and greater state control of mental hospitals. In a scenario much like the present, state governments ordered many hospitals to improve patients' treatment but spend less money (4).

The movement to reform psychiatric services included attempts to design better hospitals and to formulate alternatives to hospitalization. Dr. Thomas Kirkbride developed a practical, livable architectural plan for hospitals, consisting of a central administration building with wings on each side to house patients (17). Later, hospitals were built on a plan that consisted of a central administration building surrounded by separate small buildings or cottages for patients (1,5). Reformers also suggested services such as community care in private homes and parole of patients with nonchronic conditions to work in the community. Few of these ideas came to fruition on a large scale, however, and some were

openly fought by prominent psychiatrists of the time (4).

By the end of the 19th century, the situation in the overcrowded mental hospitals had gone from bad to worse. Qualified staff were difficult to keep, and abuse of patients was common; the physical plants of many hospitals were deteriorating (18). Some of the alternatives that were tried included a system of small county hospitals in Wisconsin and Pennsylvania and a cottage system developed in Kankakee, Illinois (18). In addition, perhaps the first formal outpatient service was initiated in 1885 when a twice-weekly clinic was begun at the Pennsylvania Hospital. Several such hospital-based clinics sprang up in the early 20th century (5). Inpatient services in large mental hospitals, however, continued to constitute the great majority of psychiatric services offered.

Improving the asylums

Dr. Adolf Meyer, a physician at the Kankakee hospital in the early 1890s, became committed to improving mental hospital life and developing programs for community care and prevention (2,13,19). He believed that hospitals should serve a limited geographic area and a defined population, in contrast to the norm of large, isolated hospitals serving a large portion of the state population. He also promoted model clinics located in the communities they served, as well as model schools for children. His concept of a clinic included outpatient and social work services, as well as inpatient services (20). In 1912 Meyer became director of the new Henry Phipps Psychiatric Clinic at the Johns Hopkins School of Medicine, one of the prime examples of the trend toward new psychiatric services.

Although many hospitals physically separated "incurables" from other patients, specific services for patients with milder disorders were conceived for the first time in the early 1900s. The first psychiatric ward in a general hospital was created in Albany in 1902 for the "treatment of incipient or transitory mental disturbances." This trend was continued at the first university psychopathic hospital, opened at the University of Michigan in 1906, which emphasized prevention and outpatient services (2).

Also in the early 1900s, optimism about the possibility for improvement of mentally ill patients returned. Although cures were still thought to be rare, attention turned to the prevention of mental disorder. The importance of environmental factors in the etiology of mental illness was also recognized. Dr. Thomas Salmon, the APA president in 1917, noted that the future looked bright: the field had a new research orientation (fostered at the University of Michigan and the Boston Psychopathic Hospital), a belief in an environmental etiology of mental illness, and clinical and consultative involvement of psychiatrists in schools and the courts (2).

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Psychoanalysis, which began to be offered in the U.S. in the early 20th century, also created optimism. Although psychoanalysis was used as a treatment modality with only a select group of patients, Adolf Meyer introduced psychoanalytic thought into the New York State hospital system, training staff to use psychoanalytic concepts to understand patients. Others introduced psychoanalytic staff education into the University of Michigan and the Boston Psychopathic hospitals (2).

A turning point in the development of psychiatric services was the 1908 publication of *A Mind That Found Itself* by former patient Clifford Beers (21–23). This book had roots in the 19th century tradition of criticism of the asylums and built on Meyer's belief in an environmental etiology for mental illness and the placement of services in communities. It was instrumental in the formation of the mental hygiene movement.

The mental hygiene movement

The mental hygiene movement, which flourished from 1908 to 1950, expanded the concept of mental health services to include social work services, outpatient clinics, and aftercare (1,16,18,19,24). The movement was based on the view that mental disorders were caused by a poor environment in childhood and by inherited deficiencies. Intervention in childhood behavior problems, largely through the schools, was believed to be required to prevent mental disorders (2).

After World War I, a new private organization, the National Committee on Mental Hygiene, launched public education campaigns that created interest in child development and led to the founding of the child guidance movement. Unfortunately, like the "curability" movement of the 19th century, this movement raised unrealistic expectations. A five-year study begun in 1922 to test the effectiveness of child guidance clinics found that child guidance did not change the incidence of psychosis and neurosis in children, and another well-meaning effort to serve mentally ill persons gradually deteriorated into pessimism (2).

The mental hygiene movement had a darker side. Its theories of the environmental and hereditary causation of mental disorder (19) led many adherents to support marriage regulation, immigration restriction, and involuntary sterilization. These views had their most extreme expression in the eugenics and nativism movements of the late 19th and early 20th centuries (25,26). A total of 18,552 mentally ill persons were sterilized before opposition forces and reaction to news about atrocities in Nazi Germany brought these practices to a halt (18).

Meanwhile, in mental hospitals the patient population was growing, and most services were custodial. An increasing proportion of the patients were chronically ill or elderly, and

many patients were paretic (19). New treatments, such as insulin shock, prefrontal lobotomy, and electroconvulsive therapy, were developed, but questions about their effectiveness remained. Also, psychiatrists increasingly were moving out of the institutions into other service settings where fewer chronic patients were cared for, such as outpatient clinics, child guidance clinics, and private practice (19). The practice of psychoanalysis became more popular, although its use was limited to relatively few practitioners and patients (18,22,27).

Deinstitutionalization

During World War II, as Schneck (23) observed, the "need for psychiatric services increased enormously and the armed forces trained nonpsychiatric physicians to fill the demands." In the civilian sector, new services arose in the 1940s and 1950s. Day treatment is said to have begun in Montreal in 1946, but it did not become widespread until the mid-1950s (28). Similarly, the halfway house movement, even though it has roots far in the past, did not have significant effects in the U.S. until the late 1950s (29). The therapeutic community also came into its own in this era (30,31).

The development of alternatives to hospitalization was accompanied by the unfortunate tendency to view all psychiatric hospitalizations as undesirable (31,32). Hospitals, which had once been seen as the "cure" for mental illness, were now seen as quite the opposite. Huge institutions, often housing as many as 5,000 or 6,000 patients, were thought to cause "social breakdown syndrome" or "hospitalism" (2,31–33). This view of hospitalization, in addition to the development of antipsychotic medication and the therapeutic community and decentralization of the hospitals into geographic wards, led to closer connections with patients' home communities (31). It also set the stage for a drastic reduction in the resident populations of large public mental hospitals (34) and for the closing of some hospitals.

The process of deinstitutionalization led to a dramatic decrease in the number of resident patients in public hospitals between 1955 and 1970 (35). Although few public patients had access to outpatient care before 1950, the number of patients served in outpatient settings and in public and private community-based inpatient settings increased substantially between 1955 and 1970 (36,37).

Community mental health centers

The seeds of the community mental health center (CMHC) movement were sown in 1946 with the passage of the National Mental Health Act (38). The act created the National Institute of Mental Health (NIMH), which began operation in 1949 (39). For the next decade, according to Bloom (31), "NIMH became both the intellectual and financial source for much that was innovative." In 1955, in part because of the outcry about conditions in the state hospitals (39), the Mental Health Study Act was passed. This act created the Joint Commission on Mental Illness and Health and resulted in a landmark report to Congress in 1961 entitled *Action for Mental Health* (40). As a direct result of this report, Congress passed measures authorizing CMHC construction and staffing in 1963 and 1965 (31,39).

Compared with the slow appearance of new services between 1844 and 1963, new services during the CMHC movement appeared at a fevered pace. Each CMHC was required to have five "core" services: inpatient, outpatient, emergency, partial hospitalization, and consultation and education. Later, requirements for other services, including diagnostic, rehabilitation, precare and aftercare, training, and research and evaluation services, were added. In 1968 rehabilitation services for alcoholics and narcotics addicts and program evaluation services were authorized. Special services for children were authorized in a 1970 modification of the original act (31). The CMHC Amendments of 1975 authorized 12 basic services, which included the five original services plus services for children and the aged, follow-up for patients formerly in state institutions, screening before admission to the state hospital, alcoholism services, drug abuse services, and transitional housing (39).

Although these new services created optimism among many mental health advocates, the CMHC movement was not without its detractors. Politically, the Nixon and Ford administrations were firmly opposed to the program (31). The 1980 Mental Health Systems Act, which would have provided for the coordination of services, for patients' rights advocacy, and for grant programs for underserved populations, was never implemented (39) because of stiff opposition from the Reagan administration. That administration turned CMHC funds over to the states in "block grants" (31), which led to the de facto elimination of many of the core CMHC services because they were no longer federally mandated.

Even within the psychiatric profession, opposition to the CMHCs was intense. Some decried an overemphasis on social reform rather than clinical treatment (41), while others argued that the CMHCs would encourage demedicalization (42) and deprofessionalization (43). But notwithstanding these criticisms, there can be no doubt that the CMHCs had a profound effect on the availability of services in the public sector.

The CMHC movement also ushered in a plethora of services that, although not formally authorized by the legislation, were congruent with the CMHC philosophy. Vocational rehabilitation, social skills training, and other rehabilitation programs for chronic mentally ill patients gained new life in the 1970s (44,45). Case management, a part of the aborted Mental Health Systems Act, became an important service in the 1980s (46), although the character of this service varied widely (47). The number of special programs for homeless mentally ill persons (48) also grew in the 1980s, and alternative services for special populations, such as persons living in rural areas, were promoted (49).

A new dark age?

Although innovative new services continue to be created, the dominant trend since the early 1980s has been the curtailment of existing services. The history of psychiatric services in

the U.S. shows that retrenchment from previous gains and pessimism in the field are not new phenomena. However, current trends toward curtailment of services differ from those of the past in two major characteristics.

First, the frenzy to control health care costs not only has affected public services but also has led to curtailment of private services (50,51). Second, at no other time in history has there been a retrenchment in the face of proven efficacy of treatment for mental disorders (52,53). Previous efforts to back away from psychiatric services, for example, during the periods following the era of moral treatment and the mental hygiene movement, have taken place in the midst of pessimism about the efficacy of treatment. Now, however, the prognosis for patients with mental disorders has never been brighter.

Despite these differences with the past, however, the underlying rationale for retreat is very much the same. Although psychiatric services have repeatedly been shown to be effective, many people maintain a deep suspicion that mental disorders are not illnesses at all, but rather moral problems under an individual's control. If mental disorders are seen as moral problems, rather than as health problems, then services for persons who are mentally ill may easily be regarded as luxuries that waste valuable resources.

This attitude, combined with an underlying fear that mentally ill persons may be dangerous or even possessed, has indirectly supported justifications for curtailing services. Complaints by representatives of third-party payers and managed care companies that psychiatric services cost too much (54,55), as well as discrimination against coverage for mental illness by health care reform planners (55), disguise the de facto view that persons with mental illnesses do not deserve care and that society need have little concern about them.

However, other recent trends suggest some positive developments. Representatives of the managed behavioral health care movement have argued that high-quality treatment can be provided at reduced costs through managed care programs that offer specialty mental health and substance abuse services apart from general medical services (56). Advocacy groups counter that managed care regularly denies care for severely mentally ill persons (57), although a recent review of care delivered to such patients in HMOs was unable to reach a definitive conclusion on this issue (58). Nevertheless, new ways of approaching the management of care do offer some potential for improvement of the present situation.

Another bright spot is the possibility of a sea change regarding the stigma of mental illness. A recent national survey for *Parade* magazine showed that 84 percent of Americans believed that most mentally ill people can function normally in society when treated, 71 percent believed that mental illness can be cured, and 98 percent thought that insurance plans should cover psychiatric services (59).

The stigma of mental illness is still very much with us, as another recent survey on public perceptions of people with schizophrenia shows (60). But as the *Parade* article points out, the general public may be ahead of politicians in overcoming prejudice against persons with mental illness. If a new "dark age" in psychiatric services is ushered in by insurance companies and policymakers looking for higher profits and political expediency, it may be at the expense of their credibility with the public at large.

Although there are promising signs that a new dark age can be avoided, powerful forces may make it a reality. As long as policymakers continue to believe that mental disorder is moral weakness and that treatment of mental disorder is ineffective and too costly, swings from enlightenment to darkness will continue, and mentally ill patients will remain at the mercy of political expediency.

Whether we are presently entering a new dark age or a new age of enlightenment, history teaches us always to be watchful for change as the pattern of concern about mentally ill persons continues to unfold. In 1969 Gerald Caplan (61) commented on the ebb and flow of interest in mental disorder among politicians and lay persons "and the oscillations in their attitudes concerning the importance of providing significant resources for the care of the mentally ill." Caplan cautioned against placing too much emphasis on intermediate-range planning, which assumes that attitudes and interest will stay relatively constant (and positive). His admonition remains quite appropriate today.

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