

Government and Mental Health Policy: A Structural Analysis

GERALD N. GROB

Rutgers University

MENTAL HEALTH POLICY ARISES OUT OF THE interaction of many different variables. Sometimes policy is shaped by broad agreement on a specific priority. In the early nineteenth century, for example, a consensus emerged around the belief that the care and treatment of severely mentally ill persons required the creation of a system of public asylums. Policy, however, is also shaped by elements having little to do with specific priorities. These include (but are not limited to) the composition of the mentally ill population; the means for dealing with disease and dependency; concepts of the etiology and nature of mental illnesses; the organization and ideology of psychiatry; funding mechanisms; and existing popular, political, and professional values and attitudes. An often neglected but significant factor in shaping policy is the very structure of the American political system. There is a distinct tendency to neglect structure, if only because of the widely held assumption that other more fundamental determinants shape social and political processes.

In this essay I will analyze how intergovernmental relations—local, state, and federal—both shape and transform social policy in general and mental health policy in particular. This is not to argue that policy is defined by structure. It is merely to suggest that structure can transform

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priorities, which in turn reshapes the content of policy in distinct ways. Substantive changes in mental health policy within the American context often create incentives to shift responsibilities to other levels of government. This, in turn, transforms and distorts coverage patterns and thus inadvertently alters both costs and policy goals.

Early Mental Health Policy

In the years following the American Revolution, political leaders were preoccupied with the problem of creating a new framework of government. The writing and ratification of the Constitution institutionalized the earlier experiences with centralized authority by restricting the functions of the new federal government and by retaining a large reservoir of power for the states. The tenth amendment explicitly stated that the "powers not delegated to the United States by the Constitution . . . [were] reserved to the States respectively, or to the people." However the Constitution is interpreted, it is clear that its authors believed that responsibility for health and welfare resided with state and local governments, not with the national government.

The assignment of responsibility for social welfare to states and communities did not imply that either one would formulate a coherent mental health policy. Before 1800, as a matter of fact, insanity was neither defined in medical terms nor identified as a pressing social problem. A predominantly rural society cared for "distracted" persons or "lunatics" — to employ the terminology of that era — in a variety of informal ways and within the framework of either existing poor laws, private charity, or a combination of both. There is little evidence, moreover, to substantiate the oft-repeated allegation that insane persons were singled out for unduly harsh and inhumane treatment. Given prevailing standards of living, available resources, and the absence of any institutions, there is no reason to suggest that the fate of the insane was appreciably different from other dependent groups. Fiscal concerns, although always present, were modified by long-standing ethical and moral values that were predicated on the assumption that society had an ethical and moral obligation to assist those unable to survive independently (Grob 1973; Jimenez 1987).

Rise of the Mental Hospital

In the early nineteenth century, however, a profound transformation occurred in the ways Americans perceived mental illnesses and in the priorities they set for the care of insane persons. In brief, the older ad hoc ways in which local communities dealt with insanity were largely abandoned and were replaced by a policy that emphasized a novel institution—the asylum, retreat, or, mental hospital. In the decades following its appearance in the 1820s and 1830s, the asylum became the first priority for public policy—a position that it would retain until after World War II.

The founding of public hospitals, however, did not occur in a social or political vacuum. The tradition of local autonomy that had grown out of nearly two centuries of colonial experience continued to influence both the creation and administration of welfare policies. Many of the early state laws pertaining to insanity, therefore, were based on the assumption that policy had to embody shared responsibilities with local communities. Thus, an older tradition of local autonomy continued to play a role, even at a time when rapid social and economic change pointed toward greater centralization (Grob 1973).

Public policies, to be sure, varied from state to state and region to region. State legislatures generally provided the capital funds necessary for acquiring a hospital site, constructing the physical plant, and often even paying the salary of superintendents and other officers. Local communities, on the other hand, were required to reimburse the hospital for the costs of caring for and treating each resident. The system, moreover, did not assume that all insane persons would be cared for in state institutions. A high priority was set on committing dangerous insane persons, whereas others who could benefit from a therapeutic regimen could be committed at local discretion. In short, the system involved dual responsibility, even though the state assumed the costs of patients who lacked a legal residence, such as immigrants.

Impact of a Divided Authority

The division of responsibility for the mentally ill between two levels of government had significant repercussions. Most important, the system tended to promote competition and rivalries that were inherent in over-

lapping jurisdictions. The stipulation that communities were financially liable for their poor and indigent insane residents created an incentive to keep them in local almshouses where per capita costs were lower. If the state assumed greater responsibilities, localities were more enthusiastic about using hospitals, if only because it relieved them of fiscal burdens. The funding patterns in many states, as a matter of fact, played a decisive role in determining whether mentally disordered persons would be placed in asylums, almshouses, or simply left on their own.

Nor were public asylums immune to the prevailing division of authority. Patient fees, generally set by the legislature, were often insufficient or marginal; slow and delinquent payments by local officials caused severe cash-flow problems; and inadequate or tardy state appropriations further compounded institutional problems. Hospital officials, moreover, faced unremitting local pressure to discharge patients irrespective of therapeutic considerations. In a few extreme cases, local officials inaugurated legal proceedings against hospital authorities in the hope of recouping money for the labor of their patients, even though such work was part of a therapeutic regimen (Grob 1966, 1973).

Aware of the problems arising out of divided authority, some states—particularly those in the more recently settled western areas—assumed responsibility for all costs associated with hospital care. By 1860 Ohio, Indiana, Illinois, Wisconsin, and California paid the full costs of hospitalization; six states limited their support to indigent patients only (Worcester State Lunatic Hospital 1862). Others adopted variations, including an annual fixed appropriation. Although easing tensions, such modifications failed to resolve existing difficulties, if only because there were always more patients than beds in state hospitals. This situation forced local communities to develop their own ways of providing care for dependent insane residents.

During the nineteenth century, the federal government played no role whatsoever in mental health policy. Although its authority expanded during the Civil War and Reconstruction, federal domestic obligations remained limited or nonexistent (excepting pensions to war veterans and their families). Social and mental health policy remained the responsibility of the states. Indeed, the costs of administering a system of public asylums soon constituted one of the largest items in many state budgets, a fact that suggested a high priority accorded to institutional care and treatment.

An Abortive Federal Role

In 1848 the redoubtable crusader Dorothea L. Dix attempted to persuade the national government to use its resources to assist states in this matter. She petitioned Congress for legislation that provided for the distribution of five million acres of federal land to the states, the proceeds of which were to be used to support the indigent insane. The idea was by no means novel, for a precedent already existed. The construction of a national railroad network would have been impossible without massive federal land grants to private corporations. For six years Dix assiduously lobbied members of Congress in an effort to overcome the attitude that the government did not possess constitutional authority to use the public domain for such purposes (Grob 1973).

In early 1854 Dix's labors bore fruit. The Senate and House enacted legislation setting aside ten million acres for the states, the proceeds of which were to be used to support the indigent insane. Dix's joy at her success proved of short duration; the act met with an executive veto. In his explanatory message President Franklin Pierce employed oft-repeated arguments. If the bill became law, he observed, "the fountains of charity will be dried up at home, and the several States, instead of bestowing their own means on the social wants of their own people, may themselves, through the strong temptation, which appeals to States as to individuals, become humble suppliants for the bounty of the Federal Government, reversing their true relation to this Union" (Grob 1973). When the veto was upheld by a wide margin, the issue of federal support disappeared from any political agenda. The only major federal statute relating to the mentally ill was enacted the following year; it provided for the establishment of the Government Hospital for the Insane (later St. Elizabeths Hospital) in the District of Columbia. The only other federal statute enacted before 1900 was one that excluded insane immigrants from entering the country.

The veto of Dix's bill precluded any expansion of the role of the federal government. For the remainder of the nineteenth and part of the twentieth century, policy agendas regarding the mentally ill were set at the state level. The division of responsibility between local communities and state governments that had been characteristic from the very outset persisted. Because the capacity of state institutions always lagged far behind the numbers of potential patients, large numbers continued to be

cared for in local institutions or within the community at large. Major urban areas such as New York, Philadelphia, and Boston had local institutions that rivaled and in some cases exceeded in size their state counterparts.

Public Policy Issues

Beneath the rhetoric that accompanied debates over the proper configuration of public policy lay a series of complex issues. At any given moment a proportion of patients admitted to hospitals failed to recover, and thus required care for extended periods. The growing numbers of chronic cases raised difficult problems insofar as the setting of priorities was concerned. Should states build additional hospitals? Did the presence of chronic patients undermine therapeutic goals? Should local communities continue to retain chronic and severely mentally ill persons in almshouses or other welfare institutions? What level of government—local or state—should bear the greatest burden of support?

The answers that were offered to such questions varied widely. New York, for example, opened the Willard Hospital for the Chronic Insane in 1869, which was intended to care for all of the state's chronic patients. But Willard was not adequate to the task. Within a few years the legislature was forced to enact the Exempted Counties Act to permit localities to maintain their own institutions. Wisconsin, on the other hand, set up a system of county asylums for persistently mentally ill patients and provided a subsidy to cover part of the costs that were involved. This policy rested on the belief that state hospitals should focus on therapy and not accept responsibility for chronic cases. Eclectic solutions were characteristic. Yet friction between local and state officials over the allocation of fiscal responsibilities was characteristic. Funding, however, was by no means the only source of conflict. Local officials responsible for the care of dependent groups argued that chronically insane persons ought not to be sent to distant and remote state institutions where they were cut off from family and other personal ties. Public officials and other professional and organizationally minded individuals, on the other hand, believed that preoccupation with costs ensured that local care would always be substandard (Grob 1973, 1983).

Toward the close of the nineteenth century, coalitions that included physicians and social welfare activists began to lobby for an end to dual responsibility. New York led the way with the passage of its influential

State Care Act in 1890, which mandated that insane persons were to be wards of the state. A subsequent law provided for an increase in the state property tax, the proceeds of which were to be applied to the care of the mentally ill. Three of the largest urban counties (New York, Brooklyn, and Rochester) were exempted from the law, but their officials quickly transferred their institutions to the state in order to avoid double taxation. Over time virtually all states acted in a similar way. After 1900 state care of the mentally ill, with a few notable exceptions, became the general rule (Grob 1966, 1983).

The consequences of this radical shift in public policy, however, had unexpected results. Local communities were not unwilling to surrender their role in making provision for their chronically insane residents. But their officials also saw an opportunity to shift their welfare responsibilities in ways that proponents of state care had never anticipated. Almshouses—which were supported and administered by local governments—traditionally cared for senile and aged individuals. As the state assumed complete responsibility for the insane, local officials began to redefine senility in psychiatric terms. They proceeded to transfer elderly persons to mental hospitals and to shut down their almshouses. Humanitarian considerations played a relatively minor role; economic considerations were of paramount significance as localities transferred the burden of support to the state. The structural context of policy making, in other words, altered coverage patterns, which in turn transformed the mission of state hospitals by converting them into institutions that provided custodial care for large numbers of elderly, incapacitated persons (Grob 1983).

Mental Health Policy after World War II

The end of dual responsibility for the mentally ill gave mental health policy an aura of stability and permanence. On the eve of World War II, the United States had in place a vast public hospital system that provided care and treatment for all mentally ill persons irrespective of their ability to pay. By 1939 these institutions at any given moment cared for about 425,000 residents, even though a much larger number passed through the system within a given year. Aggregate data, however, conceal as much as they reveal. Hospitals, to be sure, had a high proportion of chronic patients composed of two distinct groups: individuals admit-

ted at a younger age but who remained hospitalized for the rest of their lives, and elderly persons who remained for a relatively brief time before they died. The large chronic population, nevertheless, shielded from view a much larger group of patients who were admitted, treated, and discharged after relatively short stays. A longitudinal study of more than 15,000 admissions between 1916 and 1950 at a Pennsylvania hospital revealed that between 61 and 72 percent of all admissions were discharged in less than one year (Kramer et al. 1955). Yet the continued accumulation of chronic cases—virtually all of whom required comprehensive care—fostered a belief that mental hospitals were simply serving as warehouses that were far removed from the mainstream of modern scientific medicine.

No public policies, however long established or stable, remain immune from broader social, economic, and intellectual currents. Beginning with World War II, the priority on institutionalization of the mentally ill slowly began to erode. Within two short decades the very legitimacy of mental hospitals was challenged by individuals and groups who firmly believed that more effective alternatives were available.

The change in priorities in the postwar era obviously had diverse roots that were unrelated, at least in their origins, to governmental structure. The experiences of World War II supposedly demonstrated that community and outpatient treatment of mentally disturbed persons was superior and more efficient. A shift in psychiatric thinking fostered receptivity toward a more psychodynamic and psychoanalytic model that emphasized life experiences, the important role of socioenvironmental factors, and psychotherapy of one sort or another. The belief that early identification of individuals at risk and intervention in the community would be effective in preventing subsequent hospitalization became more popular. This view was encouraged by psychiatrists and other mental health professionals who identified with a public health orientation. A pervasive faith developed that psychiatry, in collaboration with other social and behavioral sciences, could identify and presumably ameliorate those social and environmental conditions that played an important etiological role. The introduction of new psychosocial and biological therapies (including, but not limited to, psychotropic drugs) held out the promise of a better life for individuals outside mental hospitals. All of these developments by themselves, or in conjunction with each other, would have surely hastened change (Grob 1991).

Entry of the Federal Government

But the entry of the federal government into the mental health policy arena proved of even greater significance. It altered the very ways in which policy was to be conceptualized and implemented. Indeed, without federal involvement there is little doubt that postwar mental health policy would have followed a quite different path. Throughout the remainder of this article I will explore the circumstances that promoted this new federal presence, the policy innovations that followed, and especially the ways in which a divided political system created incentives and altered coverage patterns.

As late as the beginning of World War II the federal role in biomedical and health policy was limited. The Biologics Control Act (1902) and Pure Food and Drug Act (1906), although expanding federal responsibilities, were not harbingers of the future. Nor did the creation of the National Institute of Health in 1930 and the National Cancer Institute seven years later imply an inexorable growth of national authority. The Public Health Service, which became more visible with the appointment of Thomas Parran as surgeon general in 1936 and the immediate launching of an antivenereal campaign, still had a marginal role insofar as mental health was concerned. In 1929 Congress had authorized the creation of two federal institutions to confine and treat drug addicts and established a Narcotics Division within the Public Health Service. Both were related to the growing role of the federal government in drug addiction that followed passage of the Harrison Act in 1914. By 1930 the Narcotics Division had become the Division of Mental Hygiene, but its functions were limited and far removed from the psychiatric mainstream (Grob 1983; Harden 1986).

In the late 1930s, Lawrence C. Kolb, a psychiatrist who headed the Division of Mental Hygiene, undertook a quiet campaign to persuade Congress to establish a National Neuropsychiatric Institute in the Public Health Service. This agency was to be modeled somewhat after the National Cancer Institute. He hoped that such an organization could conduct basic physiological research into mental disorders and perhaps support work "at some strategic places" (Kolb 1939). A few professional associations, including the American Psychiatric Association, were enthusiastic. The American Medical Association, doubtful of the propriety of using federal funds for such purposes, was opposed. The coming of

the war forestalled any further congressional action on such matters (Grob 1991).

World War II proved the critical catalyst for change. The thrust toward medical specialization accelerated; new structural relations were forged among the agencies of the federal government, physicians, and medical institutions; federal funding for research increased; and the role of the Public Health Service expanded dramatically. The war also hastened changes in the nation's health care system. In 1946 the passage of the Hill-Burton Act resulted in generous subsidies for hospital construction; third-party medical insurance programs grew rapidly; and biomedical research and medical education received ever-growing federal funds. Faith in the redemptive nature of medicine ultimately led to a redefinition of access to health care as a personal right. These and other changes were hastened by the creation of a lobby made up of two groups: congressional leaders, including Lister Hill and John Fogarty; and laypersons led by Mary Lasker and Florence Mahoney. In the ensuing two decades, this coalition played a key part in dramatically expanding the health activities of the federal government (Strickland 1972; Fox 1987; Grob 1991).

The National Mental Health Act

A growing presence in health affairs, however, did not necessarily imply that the national government would seek to preempt the traditional role of state governments in providing care and treatment for the mentally ill. Indeed, the general health care system and state-supported mental hospitals were sufficiently different that a change in one did not necessarily imply a corresponding change in the other. But the National Mental Health Act of 1946 dramatically transformed mental health policy. Its passage by overwhelming votes in Congress ensured that the national government—precisely because of its dominant position in the political system and access to seemingly inexhaustible resources—would have a significant voice in the formulation and implementation of policy.

The National Mental Health Act had somewhat idiosyncratic origins. Strangely enough, no organized group was seeking such congressional action. Indeed, the passage of the act itself created a framework for the emergence of a mental health lobby that helped to redirect policy in the ensuing decades. This act was conceived by Robert H. Felix, a psychiatrist who had joined the Public Health Service and served at the narcotic

addiction facility in Kentucky before succeeding Kolb as head of the Division of Mental Hygiene toward the end of World War II. He not only wrote the legislation; he also orchestrated its movement through both houses of Congress. One of the shrewdest and most effective federal bureaucrats of his generation, Felix wanted to change radically existing priorities that had created an entrenched tradition of institutional care. His goal was to employ the prestige and resources of the national government to redirect mental health priorities.

Briefly put, Felix redefined mental disorders in public health terms. He hoped to oversee the creation of a new system of outpatient community clinics that would provide both preventive and therapeutic services for the mentally ill. His aim was to wean the nation away from its reliance on mental hospitals and to replace them ultimately with a network of community institutions that would serve the entire United States (Felix and Bowers 1948; Felix 1949; Grob 1991).

The act of 1946 incorporated three distinct goals: first, to provide federal support for research relating to the cause, diagnosis, and treatment of psychiatric disorders; second, to train mental health personnel by providing federal fellowships and institutional grants; and third, to award federal grants to the states to assist in establishing clinics and treatment centers and to fund demonstration studies dealing with prevention, diagnosis, and treatment. This far-reaching legislation also authorized the creation of the National Institute of Mental Health (NIMH) and an intramural research program. Cognizant of the significance of organizational strategy, Felix persuaded the surgeon general to place the NIMH within the National Institutes of Health, thus linking it with other research agencies such as the National Cancer Institute and the biomedical sciences in general. During the congressional hearings, some individuals expressed concern that federal funds might be used to support care and treatment of patients at state institutions. But Felix testified that the intent of the law excluded such an interpretation, and his view prevailed (*U.S. Statutes at Large* 1946; Felix 1964; U.S. House of Representatives 1945).

The National Institute of Mental Health

Most important, the creation of the NIMH introduced a radical change of sweeping proportions. Its officials would have the capacity to speak to a national constituency—a power that transcended the divergent interests of 48 states. As the federal agency most directly involved with

mental health, the NIMH could frame a national agenda and employ fiscal resources that were not committed to any institutional system. Its identification with medical science and psychiatry only enhanced the authority of its staff. Close ties with congressional leaders of both parties, moreover, permitted NIMH officials to provide the data that would ultimately reshape policy. In short, the very existence of the agency gave individuals both within and without the federal government a powerful instrument with which to promote innovation.

As a national figure, Felix adroitly used the prestige of the federal government to persuade state officials and the general public that new priorities in mental health were appropriate. In brief, he argued that a community-oriented policy would be far more effective than the existing mental hospital system in preventing and treating mental disorders and psychological problems. Under his leadership, the Community Services Branch of the NIMH developed close working relations with state officials, thereby further strengthening the growth of a national constituency. NIMH funds were used for a variety of purposes: to expand the number of community clinics; to establish demonstration projects that might develop alternatives to institutional care and treatment; and to support regional offices that would forge close relations with a variety of mental health professionals. The eclectic approach of the NIMH was also evident in its inclusion of the behavioral and, to a lesser extent, social sciences in the mental health arena. Perhaps its most significant contribution was to legitimate the importance of psychiatric and psychological services within a community setting for both the severely and chronically mentally ill, as well as for individuals experiencing personal distress of all sorts (Grob 1991).

In the two decades following the landmark legislation of 1946, the role of the federal government expanded steadily. At the outset the NIMH budget grew only at a slow pace. When it first came into existence in 1949, its appropriation was \$9 million; six years later it had only reached \$14 million. From this point on, however, the rise was dramatic. It was stimulated in part by Title V of the Health Amendments Act of 1956—a law designed to increase the supply of nurses and other public health personnel. Title V—which drew little or no attention—authorized a new program of federal grants to state and local agencies and other public or nonprofit institutions to investigate better methods for diagnosing mental disorders and to care for, treat, and rehabilitate the mentally ill. Although it had little bearing on federal-state relations, the new law

increased funds for mental health and magnified the subsequent importance of the NIMH in formulating mental health policy (*U.S. Statutes at Large* 1956). In 1959 the NIMH appropriation was \$50 million, but within five years it had tripled to \$189 million (Grob 1991).

The influence of the new federal initiative after 1946, admittedly, can be easily exaggerated. By the 1950s the expansion of health services was largely consumer driven. The popular assumption that physical and psychological health was well within reach of everyone had become pervasive. The development of psychosocial and milieu therapies, as well as the introduction of the psychotropic drugs, gave further impetus to the belief that early identification and treatment would obviate the need for protracted hospitalization of the mentally ill. Support for a community mental health program came from other constituencies as well. The Council of State Governments and the Governors' Conferences in the 1950s endorsed this approach as a supplemental means of arresting the seemingly inevitable rise in the institutional population (Council of State Governments 1950, 1953). Private foundations like the Milbank Memorial Fund and many university departments of psychiatry also added to the chorus clamoring for change. Nevertheless, the role of the NIMH in conferring legitimacy on the desirability of a community policy should not be minimized (Grob 1991).

Changes in Mental Health Priorities

During the 1950s the pressure for changes in mental health priorities generated by a federal presence was reflected in changes at the state level. Several states pioneered by adopting legislation that permitted local communities to expand their mental health services with partial state subsidies. In 1954, for example, New York enacted its Community Mental Health Services Act. Three years later California followed suit with its Short-Doyle Act. At the same time state hospitals benefited from the favorable economic climate of this decade. Between 1946 and 1960 average per capita expenditures for the maintenance of institutionalized patients rose 284 percent (153 percent if adjusted for inflation). Nevertheless, the decentralized nature of the American political system meant that any struggle to transform policy would have to be fought out within each individual state. This was, to put it mildly, a daunting task. Slowly but surely, the feeling grew that social policy would benefit if the re-

sponsibilities of states were diminished and the authority of the federal government increased commensurately. As a matter of fact, the pervasive faith in the federal government and a corresponding belief that states were backward, parsimonious, and reactionary helped to shape many policy debates on other issues, particularly civil rights. The goal of setting new mental health priorities was thus slowly incorporated into the general agenda of a liberal political coalition that was dedicated to altering the traditional balance between the federal and state governments by expanding the authority of the former (Grob 1991).

To alter governmental functions and boundaries was not an easy task. Long-standing political traditions and customs, as well as regional, state, and local loyalties, remained strong. The concept that the national government could play an effective role in shaping mental health priorities was also a novel idea. If federal responsibilities in mental health were to expand, therefore, new thinking and different solutions would be required. To overcome the obstacles to change, psychiatric activists turned to the past for guidance. Their model was the famous report on medical education of 1910 prepared by Abraham Flexner for the Carnegie Foundation for the Advancement of Teaching, a document that allegedly revolutionized the training of physicians in subsequent decades.

The Joint Commission on Mental Illness and Health

The idea for a Flexner-type report was first raised in 1953 by Kenneth E. Appel of the University of Pennsylvania and president of the American Psychiatric Association (Appel 1953). Two years later the Joint Commission on Mental Illness and Health was established. With bipartisan congressional support, a Mental Health Study Act was passed, endorsing the work of the commission and authorizing the Public Health Service to provide federal grants. After nearly six years of work and an expenditure of \$3 million, the Joint Commission issued its final report, *Action for Mental Health* (Joint Commission on Mental Illness and Health 1961).

The analysis, conclusion, and recommendations of the document were broad rather than technical or narrow, and in many respects mirrored postwar thinking in general. It embodied a psychosocial and psychodynamic perspective, and stressed the need for environmental approaches to the problems of mental illnesses within an integrated community setting. The report argued for a broad, diversified program: a much larger

investment in basic research; a partnership between psychiatry and other mental health professions (but with proper attention to their respective competencies); a national recruitment and training program for all disciplines involved in providing services; a greater effort to render services to "mentally troubled individuals" (compared with seriously and chronically mentally ill persons); intensive treatment of the acutely mentally ill in community clinics, general hospitals, and mental institutions; establishment of one full-time clinic for each 50,000 persons in the population; provision for aftercare, intermediate care, and rehabilitation services for discharged patients; and a bold campaign to enlighten the public to recognize mental illnesses and support a national program. The report further called for restrictions on public mental hospitals. It urged that no state hospital of more than 1,000 beds be built; that no patients be admitted to any state facility having more than 1,000 beds; and that all state hospitals be converted "into centers for the long-term and combined care of chronic diseases, including mental illness." Its fiscal recommendations were equally striking: expenditures for mental health services were to be doubled in five years and tripled in ten, and a large proportion of the funds were to come from the federal government (Joint Commission on Mental Illness and Health 1961).

Action for Mental Health was a sweeping document that spelled out a vision for the future rather than a specific legislative program; its inclusive recommendations were never prioritized. Indeed, its breadth and vague language offered something to all constituencies, including proponents of institutional as well as community care. A vision, however, differs greatly from a specific program or law. Those concerned with the problems posed by mental illnesses, therefore, were faced with the difficult task of translating this vision into a legislative program capable of attracting support both within and outside of Congress.

That those committed to new community policies turned to the federal government was not surprising. By the early 1960s liberal activists manifested little confidence in state policy making; they had a far greater faith in the ability of the federal government to develop new social policies and programs. The prevailing consensus during the 1960s was that states had been deficient in meeting their social welfare responsibilities. Although paying homage to the idea of a federal-state partnership, many promoted policies designed to diminish the role and authority of state governments and to forge direct relations between the federal government and local communities.

Comprehensive Services as a Response to the Commission Report

Critics of state social policy making received indirect but crucial support from the NIMH. Led by Felix, most of the agency's key personnel believed that states lacked both the knowledge and capacity to institute meaningful changes, thus accounting for their continued reliance on a presumably obsolete mental hospital system. They were particularly critical of the recommendations of the Joint Commission. Despite their hostility toward the commission's recommendations, the NIMH staff had not developed a comprehensive program of their own. At about the same time a number of state officials persuaded the surgeon general to create an ad hoc planning committee, which developed a plan involving a coordinated system of services that served geographically defined limited areas. This plan implied an expansion of community facilities and the replacement of large state institutions with smaller facilities that offered a wider variety of services (U.S. Surgeon General 1961).

The inauguration of John F. Kennedy as president in 1961 offered encouragement to those committed to an expanded federal role in mental health. Kennedy appeared sympathetic, although he was primarily concerned with mental retardation because the condition had affected one of his sisters. Toward the end of 1961 he created an interagency task force on mental health to consider the recommendations of the Joint Commission. Chaired by Abraham A. Ribicoff (Secretary of Health, Education and Welfare), the task force was actually dominated by a small group of individuals that included Felix. At precisely this moment the NIMH offered its own program. Whereas the Joint Commission had emphasized the care and treatment of the mentally ill, the NIMH preferred a more far-reaching policy that focused on "the improvement of the mental health of the people of the country through a continuum of services, not just upon the treatment and rehabilitative aspects of these programs." Within months it was calling for a veritable revolution in policy—a comprehensive community program that would make it possible "*for the mental hospital as it is now known to disappear from the scene within the next twenty-five years*" (italics in original). In its place would be a mental health center offering comprehensive services (National Institute of Mental Health 1961, 1962; Grob 1991).

In the deliberations of the task force—which were guided by Felix—it became increasingly clear that the group was moving rapidly in the di-

rection of diminishing the role of state governments and strengthening the ability of the federal government to set policy priorities. Its members were therefore prepared to recommend policies that implied not only federal funding, but also a measure of federal control over mental health services. Though they did not wish to bypass the states completely, they hoped that they would be able to alter mental health policy by informal persuasion and education. The task force in the end agreed to support a federal initiative that would "eliminate the State mental institution as it now exists in a generation." It favored instead the creation of "community-centered mental health programs." The specific recommendations of the task force were impressive and bold. Its members called for 500 centers to be built by 1970 and 1,500 by 1990. Construction would be underwritten by federal funds, and a decreasing federal subsidy would be made available for operating costs (i.e., staffing) (Atwell 1962; Foley 1975). Under the adroit direction of Felix, the task force had partly if not fully ignored the recommendations of the Joint Commission. Instead it had developed a synthesis that wedded the idea of centralized control with local autonomy. The Joint Commission, by contrast, had proposed strengthening the mediating and policy-making role of state governments.

Development of Community Policy

The process of policy making between 1961 and 1963 was marked by paradox and ambiguity. Political leaders and mental health professionals (with a few exceptions) accepted the sweeping claims that a community policy would overcome the intrinsic defects of mental hospitals. Yet they rarely considered factual information during their deliberations. Data collected by the NIMH's own Biometrics Branch, for example, raised troubling questions. Some data suggested that the criticisms of the so-called warehousing functions of public hospitals were partly unjustified, and that any policy had to take into account a diverse patient population whose various mental disorders had different prognoses. More important, a community program was based on certain expectations: that patients would have a home to return to; that a sympathetic family or other person would assume responsibility for providing care of the released patient; that the organization of the household would not impede rehabilitation; and that the patient's presence would not cause undue hardships for other family members. In 1960, however, 48 percent of the

mental hospital population were unmarried, 12 percent widowed, and 13 percent either divorced or separated. The assumption that patients would be able to reside in the community with their families while undergoing rehabilitation was hardly supported by these data. The debate over the wisdom and desirability of community care and treatment, in effect, rested upon unrealistic presumptions (Kramer et al. 1955; Kramer 1956, 1967a,b; Kramer, Taube, and Starr 1968; Pollack et al. 1959).

Without raising any questions, Kennedy accepted the task force's recommendations. In his message to Congress in early 1963 on mental illnesses and mental retardation, he proposed a "bold new approach"—one that made the community mental health center the first priority of the new policy. Following congressional hearings and complex political maneuvering that resulted in the deletion of funding for any staffing, Congress enacted legislation that Kennedy signed into law shortly before his assassination. The bill provided a three-year authorization for grants totaling \$150 million for fiscal years 1965 through 1967 (Foley 1975; Grob 1991).

Implications of Community Policy

Although not understood at the time, the new policy departure had major implications for the entire pattern of intergovernmental relations. Health care services historically had been under the aegis of state and local governments. Even when the federal role in health policy grew dramatically after World War II, it rarely included direct services (with the exception of the Veterans Administration, which dealt with a special population). The Hill-Burton act of 1946, for example, provided only subsidies for hospital construction. The act of 1963, by contrast, differed in several important respects. Under its provisions the federal government began to reshape policy by forging more direct relations with local communities. This departure inadvertently tended to diminish the authority and policy role of state governments and also heightened the importance of professionals and federal officials, few of whom had direct knowledge or links with mental hospitals. Congress, to be sure, had provided funding for statewide planning, which in turn had mobilized a broad, statewide constituency. But although state officials were deeply involved in planning, their authority over policy tended to diminish.

Subsequent developments further confirmed the weakening role of

states. Following an internal bureaucratic struggle, Felix and the NIMH, rather than the Bureau of State Services (which administered Hill-Burton), easily won the right to write the regulations governing community centers. This victory permitted Felix to shape the new law by imposing his own priorities. When adopted in mid-1964, the regulations defined five essential services (*Federal Register* 1964). The most striking aspect of the regulations, however, was the absence of any reference to state mental hospitals. This omission reflected the NIMH belief that a radical initiative was vital if the inertia of the supposedly bankrupt institutional policy was to be overcome.

The absence of any links between new, free-standing centers and the existing mental hospital system was striking. If centers were designed to provide comprehensive services and continuity of care, how could they function in isolation from a state system that provided care and treatment for most of the nation's severely and chronically mentally ill population? Indeed, the absence of mandated links facilitated the development of an independent system of centers that ultimately catered to a quite different clientele. The new system, in effect, ignored the needs of the mentally ill who were most in need of services. The final capstone of the new system came in 1965, when legislation authorized federal operating subsidies for centers. Under the terms of this act, awards were made by the NIMH through a process that effectively bypassed existing state mental health agencies.

A system that gave local centers considerable autonomy and freedom from state regulation obviously encouraged experimentation. But the weakness of any oversight mechanisms also permitted centers to move in directions not always conducive to the welfare of the severely and chronically mentally ill. Many centers, as a matter of fact, ultimately serviced a very different kind of client. Created during a decade in which a pervasive community-oriented ideology stressed the empowerment of individuals and small groups, exempting them from the regulatory arms of state governments, centers were highly responsive to constituent pressures. These pressures tended to focus on problems with a high prevalence: marital and family difficulties, problems relating to children and delinquency, and substance abuse. Serious and persistent mental illnesses, by contrast, had a much lower prevalence. Hence, it was not surprising that centers reflected the priorities of their surrounding constituents (Grob 1991).

The Severely and Chronically Mentally Ill

As its clientele broadened, the mental health system began to resemble the medical health system; both tended to relegate chronic illnesses to a secondary position. The severely and chronically mentally ill—like other chronically ill groups—presented daunting problems. They were not always easy to manage, and they often required comprehensive care. Needs that in mental hospitals were at least minimally satisfied were not as easily addressed in community settings. Who, for example, would ensure that mentally ill persons would have access to housing, food, support systems, and jobs? Who would make sure that mentally ill persons took their medication? To provide for the mentally ill in the community, in other words, was time consuming and arduous. The available means of administering programs—despite the confident rhetoric of these years—were not always adequate. The result was that the needs of individuals with severe and persistent mental illnesses were deemphasized. The federal government, moreover, was in no position to ensure that the new centers would follow the intent of the legislation under which they had been created.

State officials became acutely aware that many federal initiatives in the mid-1960s were undermining their authority. At a conference of state officials convened by the NIMH in 1966, participants immediately focused on the absence of any coordinating mechanisms within the new mental health system. Some were critical of the changes in the respective roles of the federal and state governments, and expressed concern as well about the growing “dichotomy between state hospital[s] and community programs.” They were not opposed to community centers as such, but emphasized that many had made no plans “for accepting responsibility for the seriously ill.” Stressing the comprehensive services offered by state institutions in many communities, they insisted that there was need “for a single system of services” (National Institute of Mental Health 1966). Such a system would require planning and coordination between the state and local systems. These and other expressions of concern had little impact, however, if only because federal legislation and regulations had effectively diminished the regulatory authority of state mental health officials.

The federal effort to shift the focus from mental hospitals to community centers by providing subsidies for construction and staffing, however, quickly lost momentum. By 1967 Johnson and the Congress had

become preoccupied with the Vietnam War. The rapidly escalating military budget quickly created pressure for cuts in domestic programs. Under such circumstances, it was not surprising that the number of centers actually created fell far short of the original projections. Federal policy making, therefore, led to contradictory outcomes: the focus of policy tilted toward a community emphasis; the original fiscal commitment to build centers was honored in the breach rather than the observance; and centers that were established did not usually deal with the severely and chronically mentally ill.

Federal influence was felt in other ways as well. The interpretation of the National Mental Health Act of 1946 precluded federal support for patients in public mental hospitals. But a series of far-reaching changes in the Social Security system had a dramatic, if unplanned, impact on mental health policy. In 1960 an amendment to the old-age assistance and medical assistance for the aged program authorized payment for short-term treatment in public mental hospitals for up to 42 days. Two years later the Department of Health, Education and Welfare revised its regulations to permit welfare payments to conditionally discharged psychiatric patients. This move was designed to facilitate the release of such patients. The most important changes came in 1965 with the passage of a series of complex amendments to the Social Security Act. Title 18 (Medicare) dealt with hospital insurance for the aged and insurance for physicians' services; Title 19 (Medicaid) involved grants to the states for medical assistance programs for indigent persons (Grob 1991).

Enactment of Titles 18 and 19

The consequences of the enactment of Titles 18 and 19 were profound. Medicare became an important source of funding for mental hospitals because the program provided payments for elderly patients. States like New York, which had the largest aged institutionalized population in the nation, benefited the most. In many ways Medicare altered the National Mental Health Act of 1946, which had precluded federal support for patients in public mental hospitals. More significantly, Medicaid led to a rapid decline in the number of aged persons in mental hospitals. Medicare payments for elderly patients in mental hospitals were always severely limited. Many states, therefore, changed their policy in precisely the same ways that localities had done following the passage of state care acts a half century before. Instead of caring for elderly patients in mental

hospitals, states began to send them to chronic care facilities such as nursing homes. In this way they would be eligible for Medicaid funds. In 1962, 153,000 patients in public hospitals were 65 or older; by 1972, the number had fallen to 78,000. Between 1963 and 1969, by way of contrast, the number of elderly individuals with mental disorders in nursing homes rose dramatically from 188,000 to 368,000. The decline in aged patients in mental hospitals was not synonymous with deinstitutionalization. It represented instead a lateral shift from one kind of institution to another. Funding mechanisms once again shaped the administration of policy as well as coverage patterns. An unintended and unexpected benefit was the improvement in quality of acute care and treatment in state hospitals because of the decline in the long-term chronic population. Thus one federal initiative was designed to eliminate mental hospitals, while another had the effect of enhancing their therapeutic capabilities (National Institute of Mental Health 1974; Kramer 1977; Goldman, Adams, and Taube 1983; Gronfein 1985).

The involvement of the federal government in mental health, therefore, gave rise to consequences that were neither predictable nor necessarily compatible. The creation of a community-based system dramatically broadened the clientele of the mental health system, which in turn created new constituencies whose interests were often distinct from those of the serious and persistently mentally ill. While strengthening its links with local communities, the federal government also weakened the policy and regulatory roles of the very state governments that administered a large institutional system caring for the most severely mentally disabled part of the population. Funding also became more varied with the passage of legislation that dealt with disability, dependency, and illness, but indirectly impacted as well on the mental health system.

The Post-Johnson Years

During and after the 1970s the context of federal policy making shifted dramatically in response to a new political environment. During the Nixon presidency, there was a determined effort to eliminate many of the community programs that had grown out of Johnson's Great Society initiatives. To be sure, the community mental health center program survived in a truncated form. Nevertheless, it was obvious that community centers had not replaced state hospitals. After the Ford interregnum, Jimmy Carter established a presidential commission to create a

new political consensus to deal with the problem. Although not entirely successful, the President's Commission on Mental Health produced a lengthy report that led to the passage of the Mental Health Systems Act of 1980. Ronald Reagan's victory and the subsequent enactment of the Omnibus Budget Reconciliation Act, however, rendered the issue moot. The new budget legislation repealed the Mental Health Systems Act and replaced it with block grants to the states for alcohol, drug abuse, and mental health services. The federal government, in effect, simply became a conduit through which funds were returned to the states, although at sharply reduced levels. The decline in federal funding for various social programs placed an even greater fiscal burden upon the states as well as local communities.

The diminution of the federal role in mental health, however, was more apparent than real. The expansion of federal entitlement and disability programs had a dramatic effect upon the severely mentally ill. The Medicaid program, as previously noted, led to the exodus of large numbers of elderly patients from state hospitals. 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 50 and over to receive disability benefits. The Social Security Disability Insurance (SSDI) program continued to become more inclusive in succeeding years, and 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 because federal payments presumably would 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 (*U.S. Statutes at Large* 1972; Johnson 1990).

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 decline in inpatient populations was modest, 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. Lengths of stay dropped correspondingly; the median stay for all patients was 28 days, suggesting that public hospitals still had an important role in providing psychiatric services for a highly disabled population. Moreover, schizophrenics accounted for slightly more than a third of all mental hospital admissions, whereas only 19 percent of psychiatric patients treated in general hospitals fell into this category. Indeed, 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 (National Institute of Mental Health 1990; Mechanic and Rochefort 1990; Morrissey 1989; Goldman et al. 1983).

As a result of federal entitlement and disability programs, a large proportion of severely and persistently mentally ill persons have made a more or less successful transition to community life. 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 both mobile and homeless. Their visibility on the streets often overshadows some of the inadvertent successes of "deinstitutionalization." Yet, as two authorities have recently noted, "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" (Koyanagi and Goldman 1991).

The 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 often fraught with contradictions and ambiguities. Nevertheless, individuals persist in selecting examples or

making analogies that allegedly support their preferred policies while blithely ignoring all evidence to the contrary. Those who use analogies like the "Munich syndrome" (referring to French and British acquiescence in Hitler's dismemberment of Czechoslovakia in 1938) to justify American military intervention sometimes stumble into disasters like the Vietnam War. To suggest that the "lessons" of history are ambiguous is not to argue that history is irrelevant. 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 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 in unanticipated ways.

From a constitutional and structural point of view, the history of mental health policy offers some fascinating insights into the inner workings of a federal system of government that divides authority and sovereignty. The fact is that the American federal system offers both rewards and penalties, and thus shapes public policies in unforeseen and indirect ways. During the nineteenth century, state and local governments often disagreed on where mentally ill persons should receive care and treatment. As long as fiscal responsibility remained divided, communities attempted to minimize expenditures by maintaining mentally ill persons in almshouses, where costs were generally below those at state hospitals. But when states responded by placing all mentally ill persons under their authority, communities not only reduced their almshouse populations, but also redefined senility in psychiatric terms in order to transfer aged persons to state hospitals.

After World War II the arena of conflict shifted as the proponents of change turned to the federal government for leadership. Initially state officials tended to support new federal initiatives. But by the 1960s the federal government had adopted priorities that embodied a faith in the superiority of community care and treatment. In so doing they began to bypass state agencies and to deal directly with local communities. The erosion of state authority had dramatic consequences. There were now few constraints upon community mental health centers, and many of them overlooked the needs of severely and persistently mentally ill persons, emphasizing instead the creation of services for other categories of patients. During and after the 1970s, the expansion of entitlement and

disability programs inadvertently strengthened the policy of deinstitutionalization by providing resources that enabled severely and chronically mentally ill persons to live in the community. 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 was also the most significant "federally sponsored program affecting deinstitutionalization" (General Accounting Office 1977).

It is critical, therefore, to take into account the ways in which intergovernmental relations can mediate and transform the content of policy. Any effort to reshape the mental health system must include an effort to predict and to model the incentive effects that structure and intergovernmental relations have on policy. To formulate policy in a structural vacuum is to ensure that unpredictable consequences will follow. That the federal government will be involved with mental health policy is a given, if only because mental health cannot be considered in isolation from health policy generally. Indeed, a good case can be made for an argument that the general health care system can benefit from the experiences of the mental health system, which, since its inception in the early nineteenth century, was involved with chronic mental illnesses. Although chronic illnesses after 1900 emerged as the most significant health problem, the health care system remained biased in favor of acute illnesses.

However the federal government deals with health policy, it is essential that those involved in its formulation and implementation be aware that intergovernmental rivalries have the potential to alter priorities and policies in unanticipated and not always beneficial ways. From a narrow point of view, the concern at all levels with "capturing" funds is understandable. From a broader perspective, a preoccupation with "capturing" funds may be counterproductive, if only because it promotes inappropriate, improper, or inefficient practices. Efforts to shift costs, moreover, make little sense from an economic vantage point; an expenditure is an expenditure irrespective of the origin of the funds. Although it is impossible to eliminate intergovernmental issues as an element, it is important that this fact of life be taken into account in any debate over particular policies.

Policy debates have, understandably, focused on substance and often ignored the American constitutional framework of government. Yet gov-

ernment structure is a significant component, and cannot be easily ignored. To argue so is not to suggest that the framework of government should be radically altered; *all* governmental structures, after all, have consequences for policy. It is only to suggest that those who emphasize substance to the exclusion of structure, at least within the American context, may unknowingly promote unpredictable consequences that are not always to their liking.

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Address correspondence to: Gerald N. Grob, PhD, Rutgers University, Institute for Health, Health Care Policy, and Aging Research, 30 College Avenue, New Brunswick, NJ 08903-5070.