

6-2013

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Running head: HISTORY OF MENTAL ILLNESS

Mental Illness: A History with Respect to the Care and Treatment of the Mentally Ill,
Law and Public Policy, and the Stigma Attached to the Affliction

By

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Submitted in partial fulfillment of the requirements for

Honors in the Department of Psychology

Union College

Schenectady, NY

June 2013

ABSTRACT

ANWER, RAISA Mental Illness: A History with Respect to the Care and Treatment of the Mentally Ill, Law and Public Policy, and the Stigma Attached to the Affliction. Department of Psychology, June 2013.

ADVISOR: Dr. Kenneth DeBono

This thesis contains the exploration of mental illness starting with how mental illness is defined today. The history of mental illness in America reveals a gross neglect of those afflicted with “madness,” as it was usually referred to. This thesis will focus on the treatment of the mentally ill from the 1900s to present day. There is an inherent stigma attached to mental illness and as modern and as civilized as the United States claims to be, it should be noted that mental illness is still as much taboo even today, rife with stories of the mentally ill being constantly stigmatized for their illness. This paper will also focus on the representation of mental illness in the legal system and how the mentally ill are viewed through the lens of the law, with specific insight into the treatment of mental illness with respect to law and public policy in the United States from the 1900s to today. There will be a further discussion of potential healthcare and legal reforms that may be instantiated to improve treatment of the mentally ill today so that they may live to see a better tomorrow for themselves.

Mental Illness: A History with Respect to the Care and Treatment of the Mentally Ill,
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Mental illness is among the most difficult and serious quandaries facing the world today (Frank & Glied, 2006). It is especially the cause of much pain and suffering for those afflicted with mental illness and the ones who care about them (Gallagher, 2002). It is important to note that the mentally ill are not freaks of nature, as their history of treatment would suggest. Starting from the 1900s, the mentally ill suffered at the hands of public mental institutions, which was in effect a result of the public policies regarding the care and treatment of the mentally ill (Deutsch, 1946). Suffice it to say, in the first half of the twentieth century, living in a public institution for the mentally ill was not something to which any one could look forward. It was a place that reeked of despair and depression, populated by souls worn out from being mistreated by society and fighting their own inner demons. (Grob, 1983). Only toward the latter half of the nineteenth century did the situation of the mentally ill, specifically their living conditions in public mental institutions, begin to take a turn for the better (Young, 2010). One critical factor in this turn-about was the United States' federal government's involvement in caring for the mentally ill (Reamer, 1989). Despite sweeping changes that resulted from this involvement of the federal government, including better and more readily available care for the mentally ill in public mental institutions, the law had not completely advanced in its views of the mentally ill (Bell, 1989). Most of the laws detailing the treatment of the mentally ill in criminal trials had originated in the 1800s. Not to mention that most of them were more interested in criminal responsibility as opposed to mental capacity, understandably so as their goal was to remove these denigrates, as indeed that is precisely how they were viewed at the time, from society (Deutsch, 1946). With

respect to commitment laws regarding the mentally ill, many of the commitment laws had adverse effects on the care of the mentally ill (Frank & Glied, 2006). Suffice it to say that lawmakers had their own agenda when it came to enacting mental health reform, with many of them choosing cutting costs before adequate care for the mentally ill (Isaac & Armat, 1990). The mentally ill were not only suffering due to inadequate health care and uninformed laws, they were also suffering the effects of constant stigmatization (Corrigan, Roe, & Tsang, 2011). The mass media especially perpetuates a negative view of the mentally ill on the denizens of society (Callard et al., 2012). Those cases involving the rare but violent acts perpetrated by the mentally ill are constantly publicized and used as demonstrative of the general population of the mentally ill (Gallagher, 2002).

Definition of Mental Illness

In order to truly understand mental illness one must first grasp the concept of the definition, if indeed there is a set one, of mental illness. To define abnormalities in mental health, one must first define what mental health is. As the issue surrounds humans, one of the most complex beings on Earth, it is not surprising that the topic has generated much debate (McNally, 2011). It is of importance to note, however, that creating an all-encompassing description of mental health is almost impossible because there is no general agreement on what exactly constitutes “normal” behavior and understandably so, because what may be perceived as “normal” in one context, personal or cultural, may not be perceived as normal or acceptable in another. In the early twentieth century, mental health was perceived as a condition of the mind; today, it is thought to be a condition afflicting the brain (Gallagher, 2002). It should be noted that different individuals and entities have differing opinions on whether the focus should be on the brain or the mind (Callard et al., 2002). What is significant, however, is that a therapist’s

concept of mental health is more important as it can have a far-reaching influence on the patient's general outcome (Gallagher, 2002).

To diagnose mental illness properly, healthcare professionals follow the handbook prepared by the American Psychological Association, the *Diagnostic and Statistical Manual of Mental Disorders*. According to the most recent version of these guidelines, the DSM-IV-TR (text revision), "mental disorders are behavioral or psychological syndromes, clusters of co-occurring symptoms, which cause significant distress or interfere with a person's ability to function in everyday life, or both" (McNally, 2011, p. 3). Mental disorders are not confined to one specific category but in fact vary in terms of type and severity (McNally, 2011). Generally, there are thought to be four clusters of mental illness. One of these four clusters involves abnormalities in thoughts, sentiments, and interpretations (McNally, 2011). The second cluster is comprised of mental illness conditions that originate when individuals fall on either extremes of neuroticism and introversion (McNally, 2011). Of course, being extremely shy does not signal one out for a mental illness but extreme shyness coupled with the individual's situation in life and personal experiences can produce effects, which may inch them closer to developing mental illness (McNally, 2011). According to the psychiatrist Paul McHugh, the third type of cluster involves individuals' behavioral practices which may produce instant so-called positive effects for the individual but which may have seriously negative consequences down the road (McNally, 2011). Those suffering from drug addiction issues usually comprise this category. According to McNally (2011), the fourth category of mental illness, best illustrated by post-traumatic stress disorder, usually develops after an individual experiences traumatic events or injuries. Generally, symptoms of mental disorders showcase themselves when there has been a dysfunction in the operations of the mind or brain (McNally, 2011).

History of the Care and Treatment of the Mentally Ill

As Albert Deutsch (1946) correctly contended, there does not seem to have been any consistencies in the procedure involved in taking care of the mentally ill in America. The following research on the treatment of the mentally ill in America will reveal that the care and treatment of the mentally ill in the United States showed a horrifying trend before things began to change slightly for the better in the late twentieth century (Frank & Glied, 2006). Prior to the 1900s, the criminally insane were incarcerated just like other, non-mentally ill, common criminals (Deutsch, 1946). Only in the 1900s did states start building separate facilities to house the mentally ill who had transgressed the law (Deutsch, 1946). The first foray into treatment for the mentally ill began in 1902 when the Marine Hospital Service, which was given power to constrain domestic epidemics, had a new addition to its name: Public Health Service (Armour, 1989). By 1912, the Public Health Service had been granted authority to sanction research into and preclude disease (Armour, 1989).

To aid in improving conditions for the mentally ill, the early twentieth century witnessed the rise of the mental hygiene movement, which went beyond just emphasizing the treatment of mental illness (Bell, 1989). The mental hygiene movement in effect focused on early intervention, the prevention of increased mental illness in an individual, and the advancement of mental health (Grob, 1983). Whereas before there was no emphasis on prevention, the mental hygiene movement went a step further and promoted the treatment *and* prevention of mental illness (Grob, 1983). This movement sought to paint mental asylums as areas where society hid and maltreated the mentally ill as social pariahs. In effect it associated a stigma with the asylum (Bell, 1989). The movement took off with the establishment of the National Committee for Mental Hygiene (NCMH) in New York City in 1909 (Bell, 1989). It was mainly founded

through the efforts of Clifford W. Beers, who himself had endured the horrific conditions that mentally ill patients were typically exposed to in mental institutions and which he detailed in his book, *A Mind That Found Itself* (Grob, 1983). The NCMH raised hopes about improvements in the mental health system and mental health policies, as well as new innovations in treatment (Bell, 1989). The stated goals of the NCMH clearly reflected the goal of the hygienist movement, namely: “The NCMH would protect the public’s mental health; promote research into and dissemination of material pertaining to the etiology, treatment, and prevention of mental disease; enlist the aid of the federal government; and establish state societies for mental hygiene” (Grob, 1983, p. 153). Though established so early on, the NCMH would not be functional until after 1912 (Bell, 1989). A major source of its issues lay in financial problems, namely insufficient funds to carry out any of its goals or to pay salaries for those it employed (Deutsch, 1946). Beers also had a broader agenda than what his collaborators would have liked and even with funding from Henry Phipps and the Rockefeller Foundation, the NCMH did not accomplish much of what it proposed to do when it was first founded, mainly the improvement of conditions for the mentally ill in mental institutions (Grob, 1983). Despite these issues, perhaps one of the biggest contributions of the Committee was its work in modifying the label placed on the mentally ill so that it was no longer acceptable to interchangeably use *insanity* and *mental illness* (Bell, 1989). The Committee has also printed a journal called *Mental Hygiene* since 1917 (Grob, 1983).

Even with goals that would have no doubt helped the mentally ill a great deal during the early 1900s, the foundation was not very successful (Deutsch, 1946). One of the reasons for its perceived failure is thought to be the above-mentioned conflicts between Beers and his collaborators, including Adolf Meyers and Thomas W. Salmon, both of whom would resign

(Grob, 1983). Other foundations with hygienist agenda, including John D. Rockefeller's founding of the Bureau of Social Hygiene, are thought to have had more success, though admittedly they did not concentrate solely on mental illness (Bell, 1989). Their focus of social change was based on studying and treating venereal disease, prostitution, and analyzing the association between moral issues and the law (Grob, 1983).

With respect to the administrative organization of state hospitals, the beginning of the twentieth century saw the rise of state boards of control (Grob, 1983). The boards of control sought to consolidate the state's independent institutions and replace the governing authorities of individual institutions (Grob, 1983). This move was originally meant to remove responsibility of the fiscal costs of caring for the mentally ill from local institutions, and the community in general, to the federal government (Grob, 1983). The rationale behind the creation of the boards of control was to increase efficiency in public institutions and withdraw these institutions from the influence of politics so that hospitals could easily take care of their patients without being hampered by political disputes (Grob, 1983). It should be noted, though, that this policy was not easy to implement in reality because efficiency in institutions with larger populations came at the price of overlooking or ignoring, the needs of the patients (Grob, 1983). Therefore the boards of control achieved its goals better at smaller institutions with a more scant population (Grob, 1983). Not to mention, there were also costs associated with managing and implementing boards of control (Grob, 1983). Therefore, even though they may not have been as effective as intended, the establishment of the boards of control suggested that people were starting to care about institutional reorganization and structure. Indeed, the boards of control began the overture for more patient-friendly and ethical therapeutic and rehabilitation practices (Grob, 1983).

It should also be noted that by the beginning of the twentieth century, the responsibility of caring for the mentally ill rested entirely with the state (Bell, 1989). Therefore the state needed to find ways to make its hospitals more effective as they were not receiving any help, if at all, from the federal government (Grob, 1983). In fact, by 1917 only a few remaining states still maintained that local communities aid them in providing financial support for the care and treatment of the mentally ill (Reamer, 1989). To put things in perspective, consider that in New York, from 1918 to 1940, approximately 90% of the fiscal responsibility for the mentally ill lay with the state (Grob, 1983).

By the 1920s treatment for illnesses had shifted from the magic and herbal remedies of the 1800s to scientific medicine. As a result, most states increased their spending on the improvements being undertaken at public hospitals by approximately 60% (Grob, 1983). A decade later, treatment of the mentally ill had also modified to a certain extent (Deutsch, 1946). By 1937, many state hospitals had created and set up farm communities connected to the hospitals (Deutsch, 1946). This allowed certain patients to gain employment and that also in an environment conducive to their needs and medical conditions all the while permitting them to work with greater freedom than they could have otherwise been allowed (Deutsch, 1946). There was also a differentiation in institutions such that in a number of states, patients were categorized and separated into groups based on mental capacity. Those who were completely mentally deficient were taken out of mental hospitals and placed in institutions where their individual issues could be dealt with on a more specific and individual basis (Deutsch, 1946). By 1938 social work and occupational rehabilitative therapy had come to be introduced into institutions to help the mentally ill (Grob, 1983). Mental hospitals also began to categorize and classify their patients into type and acuity of illness so that patients were not randomly assigned to their rooms

and care (Deutsch, 1946). These modern hospitals began to include sessions of psychotherapy, occupational therapy, and hydrotherapy for their patients (Young, 2010). Other mental hospitals also began to instantiate physical education, sports, rhythmic exercise, and other such recreational activities into their occupation therapy curriculum (Deutsch, 1946). According to Deutsch (1946), by 1925 it seemed that an increased number of mental institutions were beginning to conform more rigidly to the rules established for mental institutions by the American Psychiatric Association.

By 1948 most states had included provisions to prevent mentally ill patients from being rendered immobile by bondage techniques or being committed to solitary detention (Deutsch, 1946). Many states had begun to adopt laws that would limit the use of mechanical restraints to implementation only in times of surgeries and emergencies and that too for a limited time by the consent of an officer (Deutsch, 1946). The utilization of powerful sedatives that would tranquilize the patient but also have adverse effects for the patient's mental and physical health was slowly cut back (Deutsch, 1946). At the same time by 1937, certain personnel changes were also occurring in the employment of mental facilities. Around the same time, oppressive "cell keepers" were beginning to be replaced by custodial attendants who were also reinforced with trained nurses; these nurses not only provided alternative care but also sympathetic care (Deutsch, 1946). In the late nineteenth century and up to the twentieth century, most superintendents of mental institutions were male, the majority of whom had no medical training. A certain shift occurred such that by 1937, more and more states required their superintendents to be physicians but, more specifically, to be physicians with psychiatric training (Deutsch, 1946). Competitive civil service examinations had also become more commonplace to facilitate the process of employing qualified health personnel in public mental hospitals (Deutsch, 1946).

Though, of course, by no means may it be asserted that things had improved so drastically for the mentally ill such that they were now being afforded much better treatment as individuals and did not have to endure much suffering in mental institutions.

It is of the utmost importance to note that not all mental institutions adhered to these “more-humane” rules established by the APA. Because despite these so-called improvements, it was no secret that many institutions for the mentally ill were in fact abandoned prisons that were then reconstructed to allow for the reception of these new types of “inmates” (Deutsch, 1946). Many of the hospitals did not have proper ventilation or adequate heating and plumbing (Deutsch, 1946). These hospitals still had “heavily barred window and conspicuously locked doors; high-walled “airing courts”; a lack of any recreational or occupation facilities, therapeutic or otherwise, forcing the patients into a deadly deteriorating, despairing idleness” (Deutsch, 1946, p. 448). Many of these institutions also did not provide well-balanced meals for their patients to consume; not only was a mental institution’s diet unhealthy, it was also completely devoid of any taste. To top it off, many of these mental hospitals also freely used straitjackets, handcuffs, and other paraphernalia required for the restraint of mentally ill patients (Deutsch, 1946). Many hospitals also spent money trying to make the exteriors of their structures look appealing while completely ignoring the fact that they could have spent that money on the scarce beds or improving equipment necessary for the rehabilitation and therapeutic needs of their patients (Deutsch, 1946).

In the first half of the twentieth century, mental hospitals suffered from excessive overcrowding (Deutsch, 1946). To illustrate this point, consider a survey conducted by the National Committee for Mental Hygiene in 1933 of state institutions during the Great Depression. Of the 104 hospitals that took part in the survey, “77 reported overcrowding, 27

found it necessary to close their doors against new admissions, while 65 were receiving commitments in excess of budget capacity” (Deutsch, 1946, p. 449). A 1934 federal census of patients in mental institutions gave further credence to these statistics by reporting that there was an 11.2% overcrowding rate in these hospitals (Deutsch, 1946). According to Deutsch (1946), ten states reported an even higher overcrowding rate in excess of 25%. Some hospitals were overcrowded in an excess of 103.8%. “In a two-year survey completed in 1933, Dr. John M. Grimes found that, in many hospitals, dining and living rooms, hallways, amusement halls, gymnasiums, porches, attics, and even hydrotherapy departments, were being requisitioned for sleeping quarters while dormitory aisles had been narrowed or eliminated entirely to make room for more beds” (Deutsch, 1946, p. 448). In 1938 approximately 153 out of approximately 5,000 general public hospitals admitted mentally ill patients (Grob, 1983). In the 1920s and 1930s, state-funded mental institution was the first place to dump the mentally ill (Bell, 1989). Mental hospital also became a relief agency of sorts and served the alternative purpose of nursing homes for the elderly who were not employed and whose families could not sustain them during the Depression (Grob, 1983).

To make the already-formidable situation worse, the Great Depression had a major adverse effect on mental institutions such that many mental hospitals had to reduce their budgets, completely end some programs, and abandon plans for expanding their institutions (Bell, 1989). To illustrate the extent of the overcrowding that was experienced during the early part of the 1900s, consider that from 1903 to 1940, the number of institutionalized mental patients increased from 150,000 to 445,000 (Grob, 1983). To deal with the overcrowding issue, many hospitals had begun to adopt a “family care” system. In this system, certain patients with long-term mild conditions or those recovering from treatment were boarded with foster families. Usually

hospitals paid approximately \$4.50 a week per patient to these families (Deutsch, 1946). In 1934 the state legislature allowed for the allotment of up to \$20,000 by each public mental institution for those mentally ill patients under the care of the State Department of Mental Hygiene so that each institution would be able to enact a system of family care for specifically chosen patients (Deutsch, 1946).

Due to the economic recession of the Great Depression in the 1930s, typical building construction for mental institutions was either reduced or completely stopped (Deutsch, 1946). The cessation of these building constructions resulted in an exacerbation of the already overwhelming-overcrowding to an even greater extent. To deal with the issue, many hospital systems began to participate in the parole system (Deutsch, 1946). The parole system allowed for the transition of mentally ill patients in which, after they were released from public mental institutions, these patients were placed in half-way houses. From these intermediate community houses, the patients would then be placed in selected foster homes chosen at the discretion of the state hospitals in each district (Deutsch, 1946). Of course, the issue that then arose was that after patients left state hospitals, there was no system to ensure follow-up and after-care for these patients (Deutsch, 1946). Another dilemma was that the families of these patients had been so hard hit by the Depression that they could not take these transitory patients back into their homes (Deutsch, 1946). As a result, many mentally ill patients ended up imprisoned during the Great Depression (Deutsch, 1946).

By the end of first half of the twentieth century, Albert Deutsch released a scathing review of mental health care in the United States in his 1948 book titled *The Shame of the States*. In the book, he discusses how individuals afflicted with mental illness deteriorated in the uninvestigated wards of state mental facilities, without being allowed access to proper care or

otherwise enduring painful therapies that had no real effect (Frank & Glied, 2006). In one especially thought-provoking and disgust-inducing passage, he wrote of public mental hospitals as “buildings swarming with naked humans herded like cattle ... pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to have almost a physical existence of its own” (Frank & Glied, 2006, p. 1). Not only did Deutsch point to the overcrowding of mental hospitals, he also revealed that many of these same hospitals were severely understaffed (Cameron, 1989). Deutsch also pointed out that in the early twentieth century, politics unnecessarily and unfortunately played a large part in the treatment of the mentally ill (1946). In some cases incoming governors would remove experienced and highly qualified leaders in a public mental institutions, for example the superintendent, by reason of them not belonging to the ruling political party of the time or not sharing the governor’s political party (Deutsch, 1946). Take for example, the case of an efficient superintendent who was immediately replaced as head of a mental hospital by the governor. The reason for his departure: the superintendent did not belong to the governor’s party and he was duly replaced by the chairman of the committee of the ruling political party (Deutsch, 1946). In at least 14 states, many hospital employees were being forced to contribute to political funds as condition of their employment (Deutsch, 1946).

To sum up the plight of the mentally ill in the early part of the twentieth century it should be sufficient to know that not only were they not being adequately rehabilitated, they were also removed from society, these so-called “civilized societies”, into the recesses of worn-out buildings that had formerly housed the bane of society, criminals (Young, 2010). Mental hospitals were generally abandoned, as they were thought to harbor the degenerates or deviants of society. According to Deutsch (1946), the need for psychiatrists and other mental health officials to validate their profession and its purpose to the general well-being of society overrode

the need to provide efficient and compassionate care to the mentally ill. Government officials, whether state or local, placed more emphasis on finding ways to transfer over the financial burden of paying for the care of the mentally ill to the federal government or other areas of the government so that they would not have to bear the burden; as a result, they did not pay much attention to the treatment of the mentally ill and policies that, on the outset were formulated with the goal of supposedly aiding the mentally ill, but in fact proved more harmful to them than useful (Grob, 1983).

By the first half of the twentieth century for individuals living with mental illness, living conditions outside of the mental institutions were only slightly better. Many individuals barely got by, living in squalor and poverty, with no real income and little hope that they could ever receive treatment (Frank & Glied, 2006). Many mentally ill individuals who did not suffer the most serious forms of their illness could resort to requesting aid from clergymen or other friends and relatives, but overall their conditions were no better and they had no other way of surviving (Young, 2010). Palliative care at the time included medication that was either addictive or had no effect whatsoever (Frank & Glied, 2006). Patients who were financially well-off, and these *were* the minority, actually received care that was more compassionate in nature because they had the means for admission in a private institution or private home care. The treatments, however, were just as inadequate and futile as those received by the less financially well-off (Frank & Glied, 2006).

Public Policy with Respect to the Mentally Ill

Mental health policy in the United States underwent striking modifications after the 1950s (Rocheffort, 1989). After the Second World War, federal involvement in mental health care began to increase slightly (Bell, 1989). Congress was first made aware of the success of

psychiatry in treating soldiers during World War Two and then lawmakers were further angered into action after finding out how many people in the United States suffered from mental illness, which translated into the National Mental Health Act of 1946 (Cameron, 1989). With the passage of the National Mental Health Act of 1946, the federal government launched a program that would focus on three major areas: “Research on etiology, prevention, and treatment; training mental health personnel; and improving local and state services” (Bell, 1989, p. 109). The passage of this act also resulted in the establishment of the National Institute of Mental Health in 1946, which allowed mental health policy to be considered at the federal level (Rocheftort, 1989). The National Institute of Mental Health started providing grants and financial aid to further research into mental illness, as well as providing financial aid to states so that they would start developing community-based health clinics to care for the mentally ill (Cameron, 1989). The National Mental Health Act of 1946 played a large role in transferring the care of the mentally ill from general hospitals to community mental health centers (Reamer, 1989). Despite all of this political reform meant to benefit the mentally ill, no real changes in mental institutions had been implemented until 1955 (Cameron, 1989). This is because 1955 was the year in which populations in public mental institutions reached their zenith, with the total population of state and county mental institutions numbering approximately 559,000 (Grob, 1983). Further investigation revealed that there had been 178,000 new admissions in 1955 alone (Rocheftort, 1989). Once Congress got wind of these developments, it passed the Mental Health Study Act in 1955 directing the National Institute of Mental Health to commission an inquiry into how the United States may deal with mental health issues moving forward (Bell, 1989). The NIMH then formed the Joint Commission on Mental Illness and Health (Rocheftort, 1989). The findings of the Joint Commission led them to propose some changes to how mental illness had been

approached thus far (Isaac & Armat, 1990). The Commission presented ideas about how to modify the public hospital system so that no hospital could exceed occupancy of 1,000 beds (Brody & Englehardt, 1980). The Commission also stipulated that each and every patient suffering from mental illness should be cared for as long as possible in the psychiatric wing of the state hospital and if further treatment was required, that a patient be transferred to a hospital with a maximum occupancy well-below 1,000 beds where there would be greater focus on treatment for the mentally ill (Isaac & Armat, 1990). The commission also promoted the creation “of community mental health clinics, with one clinic for each 50,000 persons, which would serve as a main line of defense in reducing the need of many persons with major mental illnesses for prolonged or repeated hospitalization” (Isaac & Armat, 1990, p. 75). The Commission was quite emphatic in its view that mental health education was not to be included in the list of duties for these suggested mental health clinics (Isaac & Armat, 1990). The Commission also called for more funding from the federal government for the treatment of the mentally ill (Isaac & Armat, 1990). The Joint Commission proceeded to publish its findings in a study referred to as *Action for Mental Health* (Bell, 1989). This study led to the passage of the Community Mental Health Act in 1961, which began the shift from treating mental illness in state mental hospitals to more community-based care (Bell, 1989). After New York State passed this act, other states began to follow suit with their own version of this revision in mental health policy (Bell, 1989). This act advocated the end of the construction of large mental institutions and called for the creation of community-based health centers (Grob, 1983).

John F. Kennedy further fueled interest and investigation into the mental health care of the mentally ill in the United States (Rocheftort, 1989). In 1960 John F. Kennedy created a “Secretarys’ Committee” comprising of the Secretary of Health, Education, and Welfare and

others to reevaluate the Joint Commission Report and suggest ideas for change that the administration could follow through with in its term (Isaac & Armat, 1990). In what was quite an ironic turn of events, the subsequent report argued to disregard everything that was presented in the Joint Commission Report (Isaac & Armat, 1990). The only recommendation that the Joint Commission Report posited and that this commission promoted was the creation of a mental health facility for each 50,000 populace; this new committee advocated the establishment of a new approach to health care and treatment instead of renewing previous hospitals and services as the Joint Commission had suggested (Isaac & Armat, 1990). In this new approach the clinics would have a more encompassing role than was previously suggested by the Joint Commission (Grob, 1983). One of these roles was not prevention, however, because as Kennedy suggested, “Prevention would result from strengthening community, social welfare, and educational programs to correct the ‘harsh environmental conditions’ that Kennedy declared are ‘often are associated with mental retardation and mental illness’” (Isaac & Armat, 1990, p. 77). President Kennedy was also convinced that the care and treatment of mental illness in public hospitals was the issue, not mental illness itself (Isaac & Armat, 1990). The issue was later presented in front of Congress and resulted in the passage of the Community Mental Health Centers Act in October of 1963 (Grob, 1983).

Shortly before he died, in 1963 President John F. Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act into law, which would later become known as the Community Mental Health Centers Act of 1963 (Bell, 1989). This piece of legislation provided federal funding for community health institutions (Rochefort, 1989). Of course, no one in the congressional hearings had bothered to ask what would happen to individuals and their after-care after they left these clinics, as Medicare and Medicaid Acts,

which would have aided them in paying for their care, had not yet passed (Isaac & Armat, 1990). The reason this legislation passed is that most Congressmen were more focused on saving money, meanwhile the Joint Commission had asked for a doubling and subsequent tripling of funds allocated to revitalizing existing institutions and further funds to aid research that would study and possibly find means to prevent mental illnesses (Isaac & Armat, 1990). There were approximately 500,000 patients populating mental institutions in 1963 (Frank & Glied, 2006). Congress had only been thinking about trying to save the government from funneling money into mental hospitals to take care of those patients. The Community Mental Health Centers Act of 1963 failed to take into account the chronic patient, probably in some part due to the uninformed decision that institutions and the deplorable conditions in those institutions generally resulted in the handicaps for which mental illness had been made the scapegoat (Isaac & Armat, 1990).

In 1963 the Community Mental Health Center Program was established under the management of the National Institute of Mental Health (Grob, 1983). This program was supposed to extend and further develop “community-based mental health services by providing inpatient and outpatient services, emergency care, and consultation to community agencies” (Reamer, 1989, p. 23). In turn the centers overseen by this program would provide everyone, regardless of age and type of mental illness, with the mental health services they needed (Reamer, 1989). Essentially the Community Mental Health Center Program would oversee the construction of new community mental health centers, effectively abandoning the public mental institutions that were already in existence (Young, 2010). What no one took into account was the fact that it would be easier to organize and improve existing public mental institutions instead of spending more on trying to build new centers (Reamer, 1989). Perhaps unsurprisingly so, the Community Mental Health Center Program failed and in the 1970s the National Institute of

Mental Health developed the Community Support Program to provide assistance programs for the mentally ill (Isaac & Armat, 1990).

Research, specifically the Joint Commission's *Action for Mental Health* report, provided some insight into how mental hospitals operated and how their resident patients were treated, thereby leading to some significant changes in the late 1950s and early 1960s (Bell, 1989). Many mental hospitals revised their policies of patient punishment and began to put an emphasis on positive relationships between the in-house staff and patients (Bell, 1989). Hospitals also began to instantiate treatment programs into their daily care of patients so that patients were no longer languishing in mental institutions without any hope of reprieve from their illness (Rocheftort, 1989). The innovation of chemical drugs to deal with mental illnesses also led to an increase in patient discharges (Bell, 1989). To empty hospitals, the government began passing programs such as Medicare and Medicaid in 1965 and Aid to the Permanently and Totally Disabled (APTD), which began to serve the mentally ill in 1962. Medicaid absorbed the costs for nursing home care (Young, 2010).

Along with the Community Mental Health Centers, Medicare, and Medicaid Acts, the increase in deinstitutionalization in the 1960s to the 1980s was further fueled by the lawsuits that were brought up against public mental institutions (Isaac & Armat, 1990). In the later part of the 1960s through the mid-1980s, a group of young lawyers came together, formed the Mental Health Law Project, and waged a legal war on mental hospitals, portraying mental hospitals as areas of the mental health system where patients were neglected and instead of treating them, further made their patients sicker (Torrey, 2008). Yet another factor that further aided deinstitutionalization was Supplemental Security Income, which was controlled by the Social Security Administration—a federal entity (Young, 2010). Established in 1974, Supplemental

Security Income served as a substitute for the Aid to the Permanently and Totally Disabled (Isaac & Armat, 1990). The era of deinstitutionalization resulted in approximately 54% of mentally ill patients being discharged from mental institutions between the year of 1966 and 1975. As a result of deinstitutionalization, the number of residents in state mental institutions decreased from 559,000 to 120,000 during the years from 1955 to 1982 (Young, 2010).

This era of deinstitutionalization had intensely regretful effects on mental patients. It led to many patients being discharged without being re-hospitalized or receiving the proper care and treatment that was required for them to attempt to lead normal lives (Frank & Glied, 2006). During this time period, many mental patients were released from mental institutions unprepared to enter into their communities and uneducated about their life post-institution; other patients were discharged into nursing homes which were completely uninformed about the treatment and care of patients suffering from mental illness (Grob, 1983). During this era of deinstitutionalization, approximately 40 state mental institutions were shut down altogether (Torrey, 2008). As a result, since many of the mentally ill had no place to go after they were removed from institutions and because Supplemental Security Income did not necessarily have a valid after-care program, many of the mentally ill wound up on the streets, homeless, or incarcerated (Young, 2010). After deinstitutionalization had become more prevalent in the late 1900s, there was a significant increase in the mentally ill rendered homeless, imprisoned, and victimized (Torrey, 2008). There was also a significant increase in the number of assaultive acts perpetrated by discharged patients (Torrey, 2008). A survey conducted by the New York State Office of Mental Health from 1979-1980 discovered that approximately 23% of mental institutional patients had been discharged but with no idea as to where these individuals had ended up. This number turned out to be a shockingly high 59% for one specific hospital (Isaac

& Armat, 1990). In 1985 a study checked up on 132 individuals who had been discharged from a public mental hospital. In six months' time, more than one third of the group wound up on the streets (Isaac & Armat, 1990).

In 1983 there were approximately 116,236 residents in mental institutions, which was a 79% decrease from the 559,000 in 1955 (Reamer, 1989). There were also approximately 322 mental institutions open for service in 1950; comparatively in 1984, that number had declined to 277 (Reamer, 1989). With a decline in public mental hospitals, general hospitals had begun to offer psychiatric services to patients (Cameron, 1989). New York State passed measures to reduce psychiatric beds from the current number of 20,000 in 1986 to 13,000 in the next decade (Rocheftort, 1989). The number of psychiatric beds had decreased to 15,000 by 1989 (Young, 2010). This resulted in mass maltreatment of the mentally ill such that many of them ended up in the hallways or emergency rooms of city hospitals, waiting for beds while being handcuffed to their beds or wheelchairs for days (Isaac & Armat, 1990). By the late 1980s, only one out of five individuals suffering from mental illness was treated for mental illness when comparatively, approximately 57% were seen by their regular physician (Reamer, 1989). The early 1980s also saw an increase in total private psychiatric hospital beds (Frank & Glied, 2006). Of course, only those who could afford it occupied these private beds (Frank & Glied, 2006). Most mentally ill patients were being cared for by family members who obviously did not have the adequate training necessary or the proper treatment equipment to care for them (Isaac & Armat, 1990). Furthermore the distress and agony of the mentally ill had not been made public to such a degree that a joint CBS-*New York Times* survey in 1986 revealed that a shockingly low 1% of those surveyed were of the opinion that mental illness was a significant health issue even though at the time schizophrenia constituted approximately 40% of all chronic care hospital beds (Isaac &

Armat, 1990). By 1989, approximately 20% of the population in the United States was suffering from mental illness (Rochefort, 1989). A Johns Hopkins University Medical School study discovered that at least 42% of the men and 48.7% of the women of the homeless population suffered from mental illness (Isaac & Armat, 1990). At the same time in 1990, the number of mentally ill individuals being treated in mental institutions roughly equaled the number of mentally ill patients languishing in prisons (Isaac & Armat, 1990).

Some argue that by the end of the first half of the twentieth century, society and the government of which it was comprised, had not yet established an efficient system to provide the mentally ill in society with the proper care and treatment that they needed without being bogged down in legislation and politics (Frank & Glied, 2006). In 1999, an estimated 20% of incarcerated individuals in state jails and 11% in county prisons were suffering from serious mental illnesses (Torrey, 2008). It is equally ridiculous that the Department of Corrections seemed to be the major provider of mental health care services to the imprisoned in California as evidenced by the fact that in 1993, an estimated \$21 million was spent on mental health care in California prisons (Torrey, 2008). This number ballooned up to \$245 million in 2003 (Torrey, 2008). By the late 1990s, there were approximately 40,000 blatantly dangerous individuals suffering from mental illness who had a history of violence and who were capable of perpetrating violence unless they took their medication (Torrey, 2008). Of course it is quite obvious that if they are not supervised, these mentally ill individuals will probably not take their medication; therefore when any one of these dangerous individuals was released into the general public, they had the potential of proving to be dangerous to society (Young, 2010). Take for instance, the case of Andrew Goldstein, who had only been released from a mental hospital three

years prior to murdering Kendra Webdale in 1999, a woman with whom he had no prior association (Torrey, 2008). This further highlights the lack of uniformity in commitment laws.

Though some states have outpatient commitment laws, where highly mentally ill individuals who have violent tendencies are bound de jure to take their medication under threat of compulsory commitment, many other states, including Maryland, do not have such laws so that individuals like Malcolm Tate were able to terrorize their families with no reprieve and no law requiring him to be hospitalized or to take his medication (Torrey, 2008). Studies reveal that 400,000 individuals suffering from severe mental illness refuse their medication on an almost-daily basis (Frank & Glied, 2006). One method used to encourage mentally ill individuals to take their medication is the assisted outpatient treatment, or AOT, program (Torrey, 2008). This program releases mental patients from psychiatric facilities on the condition that they take their medications and follow their general treatment regimen (Torrey, 2008). Only 42 states have implemented AOT into their legislation but not all of them utilize it as they should. Consider, for example, that in New York State an alarmingly low 6,013 mentally ill individuals have used AOT between the years of 1999 through the middle of 2007 (Torrey, 2008). This is problematic because AOT has proved most helpful in decreasing homelessness, incarceration, and violent behavior among the mentally ill (Torrey, 2008).

Even today, mental illness can lead to homelessness, and it often does, as well as imprisonment. It was calculated that approximately 30% of homeless single adults are suffering from grave mental illness in 2000 (Frank & Glied, 2006). President George W. Bush's New Freedom Commission of 2003 reported "that the mental health system is 'in shambles'". The report described excessive disability, homelessness, dependence on social programs, school failure, and incarceration in jails and prisons of the mentally ill" (Frank & Glied, 2006, p. 2).

Consider the statistic that in 2002, an estimated 3.2 million patients suffering from mental illness were receiving Supplemental Security Income or Social Security Disability Insurance (Torrey, 2008). In 2005, approximately 20% of individuals suffering from schizophrenia in San Diego were homeless; that number was 17% for those suffering from bipolar disorder (Torrey, 2008). The population of mental institutions was estimated to be 40,000 in 2006 (Frank & Glied, 2006). By 2006, approximately 12.8 million adults were living with serious mental illnesses (Torrey, 2008). Even in 2006, “people with mental illnesses may lose many of their civil rights and their liberty, either through civil commitment or by being arrested for minor crimes arising from their erratic behavior” (Frank & Glied, 2006, p.3).

What is alarming is that mentally ill individuals are still being incarcerated today. According to Gallagher, “The demographic characteristics of the mentally ill in state adult correctional facilities are roughly equivalent to the characteristics of the mentally ill in society as a whole” (2002, p. 19). The result of the shift in the role of the prison into a mental hospital has resulted in approximately 283,800 inmates with critically serious mental illness, which is roughly 16% of the total jail population (Gallagher, 2002). Therefore it should be of no surprise that the United States has the highest rate of incarceration for nonpolitical offenders (Gallagher, 2002). Though the Justice Department stated in 1999 that incarcerated inmates suffering from mental illness were more likely than other prison inmates to have perpetrated violent offenses, it should be noted that the most common charge for these mentally ill individuals was disorderly conduct and public nuisance (Gallagher, 2002). Sending individuals afflicted with mental illness to maximum-security prisons like Rikers Island in New York City is not only nescient and callous but also highly cruel and uncompassionate (Gallagher, 2002). Aside from this objectionable trend, there are also some unsettling facts about the mentally ill in adult correctional facilities.

One of these is that law enforcement officers have come to play a progressively greater role in dealing with mentally ill individuals and are now even playing a role in making decisions about the patients regarding psychiatric referrals (Gallagher, 2002). It should be noted that, quite obviously, law enforcement officers and individuals involved in the legal aspect of making these referral decisions, such as judges, are not qualified to either recognize or handle individuals suffering from mental illness (Gallagher, 2002).

Today, even though most people suffering from mental illness may receive financial aid through public social programs or private insurance, that aid may not be enough to offset the costs of treatment (Frank & Glied, 2006). At the same time, health insurance programs also tend to levy restrictions on treatments, such as the allowed number of hospital or outpatient visits (Torrey, 2008). These insurance agencies also tend to balk at certain name-brand drug coverage. Therefore, insurance coverage may result in extreme financial hardship for some individuals, especially those suffering from severe mental illness (Frank & Glied, 2006). Those suffering from mental illness are also suffering from the worst unemployment rates of any category of disabled individuals (Frank & Glied, 2006). Mentally ill individuals also tend to have the lowest earnings of any groups and their rate of going back to work is also lower than other handicapped individuals (Frank & Glied, 2006). To put things in perspective, consider a report by the World Health Organization, which computed that “mental illnesses lead to a greater collective disability burden in established market economies than does any other group of illnesses, including cancer and heart disease” (Frank & Glied, 2006, p. 2). Those afflicted with mental health issues also tend to comprise the highest occupancy in public social insurance assistance. It was calculated in 2001 that the mentally ill “account for up to 35% of those on public disability and 28% on welfare rolls” (Frank & Glied, 2006, p. 2). Even with regular payments from public social

insurance programs, the financial aid is not enough to raise these individuals over the federal poverty guidelines (Frank & Glied, 2006).

Though care for the mentally has become more accessible, some people do not receive that care because the individuals tasked with distributing aid to the mentally ill may not necessarily identify health issues of the mental nature in an individual, thereby not referring patients to the programs from which they could benefit (Callard et al., 2012). Other times, people do not seek help for mental issues because of the stigma and shame attached to mental illness or the because of a bad previous experience (i.e. lack of courtesy or competency, etc) with mental health service personnel (Callard et al., 2012).

Despite these fear-inducing statistics, there was an increase in spending on mental health services, as well (Young, 2010). An estimated \$3.3 billion was expended on mental health services in 1969 but in 1983 this number had increased to \$19.9 billion (in 1969 dollars) (Reamer, 1989). Psychiatric facilities for underage children were also established by the late 1900s (Reamer, 1989). It was estimated that between 1970 and 1981, there was an increase in the number of psychiatrists from 21,150 to 28,500 (Reamer, 1989). There was purported to have been an even bigger increase in psychiatric healthcare professionals in the 1990s, which subsequently led to an increase in the palliative care options available (Frank & Glied, 2006). Primary care physicians also began to take part in their mentally ill patients' treatments instead of instantly referring them to mental institutions (Frank & Glied, 2006). With the passage of the Supplemental Security Income (SSI) in 1972, the government could now provide disability assistance to those who needed it (Cameron, 1989). This proved to be immensely helpful to the mentally ill—especially those who were not able to hold a steady job due the severity of their illness—who were now able to have a steady source of income for the first time (Frank & Glied,

2006). This piece of health reform allowed patients to directly receive their money instead of it going directly towards the source of their health care services (Frank & Glied, 2006). In 1990 the landmark Americans with Disabilities Act, which included stipulations for those suffering from mental illness, was passed (Gallagher, 2006). This legislation required employers to make suitable adjustments so that the mentally ill could work in a variety of settings allowing the mentally ill to not only obtain jobs that they could not have before but also making it easier for them to hold down jobs (Frank & Glied, 2006). By the late 1900s, many mentally ill patients had the choice of living in psychiatric group residences, which were able to accommodate these patients by providing them with a place to stay along with surveillance and supervision from staff at these residences (Reamer, 1989). These patients also had the option of outpatient services where they did not need to stay in a facility but only needed to come in for counseling and treatment as per their individual needs (Reamer, 1989). In the last half of the twentieth century, a spectacular modification took place with respect to how the United States began to approach the necessities of the mentally ill. In fact, as a result of those changes many mentally ill individuals, including those who suffer from the most critical versions of their mental illness, do not have to be subjected to state mental institutions today (Frank & Glied, 2006).

Today nearly all of the individuals who suffer from mental illness have palliative care available to them and even if the treatment should prove to be ineffective, it is almost never inhumane (Frank & Glied, 2006). Instead of living in squalid slums, today the living conditions of those affected with the most critical forms of their illness has improved as much as the quality of living conditions has improved for society in general in the last half century (Frank & Glied, 2006). Whereas they had no reliable source of income before, today most mentally ill individuals, if they are not able to work, are entitled to obtain steady income from federal

programs (Frank & Glied, 2006). The medical care for these individuals is also paid for by either private or public insurance programs (Frank & Glied, 2006). The average expenditure for the care each mentally ill individual obtains has increased more than two-fold (Frank & Glied, 2006). Today, individuals with mental health issues and their families are more likely to receive financial aid services to help pay with the cost of treating those illness (Frank & Glied, 2006). In fact “a small army of specialty-trained psychiatrists, psychologists, nurses, and social workers, who collectively number more than two hundred thousand, has replaced the seven thousand psychiatrists practicing in 1950” (Frank & Glied, 2006, p. 2).

Whereas many family practitioners had mostly disregarded the mental health issues faced by their patients before, family practitioners today actually take part in the care that their patients receive for any mental illness they might suffer from (Frank & Glied, 2006). Individuals afflicted with mental health issues actually have more civil liberties to the extent that the law has reestablished their sense of dignity by passing legislation which prevents mentally ill patients from being committed to mental institutions without their informed consent (Frank & Glied, 2006). Essentially, the mentally ill cannot be pushed into public mental hospitals by their families and society in general who do not wish to deal with them (Frank & Glied, 2006). As a result, most mentally ill individuals lead lives in conditions that surpass the squalid living conditions endured by mentally ill individuals approximately 50 years ago (Frank & Glied, 2006). An increase in psychiatric palliative care has resulted in increasing the ability of psychiatrists to provide their patients with the most effective treatments (Callard et al., 2012). The research, therefore, indicates that even though there has been a great degree of improvement in the care and treatment of the mentally ill, that things are not yet optimal to the extent that the mentally ill may enjoy a life just as any other so-called “normal” individual may.

The Law with Respect to Mental Illness

Lawmaking is imperative in the battle against prejudice, inequality, and the maltreatment suffered by the mentally ill (Callard et al., 2012). With respect to the mentally ill, laws in the United States have mainly been passed as a way to differentiate between criminal accountability and criminal nonaccountability (Gallagher, 2002). What differentiates these two entities is “intent” (Gallagher, 2002). Criminal accountability takes into account the criminal intent of the individual (Gallagher, 2002). This is known as *mens rea*, which encompasses the idea of deliberate malignity and an understanding of malevolence or ethical wrongdoing (Brody & Englehardt, 1980). “Criminal *nonresponsibility*, on the other hand, involves two broad categories: immaturity and insanity” (Gallagher, 2002, p. 27). The immaturity category relates to the mental age of the individual. For instance, an individual who has not yet reached legal maturity or an individual who is developmentally challenged would not have a comprehension of the unlawfulness of an act (Gallagher, 2002). Insanity, on the other hand, is a legal term that has not been fully developed in psychiatry (Gallagher, 2008). It usually applies to cases in which individuals are suffering from a critical mental condition in which they have lost all touch with reality (Gallagher, 2002). This extreme form of mental derangement would allow an individual to be exculpated of his crime (Gallagher, 2002).

It should be noted that many of the standards utilized to establish insanity were primarily developed in the 1800s but are still employed today in a variety of states (Gallagher, 2002). One of the tests of insanity is the M’Naghten Rule (Deutsch, 1946). This ruling was developed to establish a distinguishing difference from the so-called “insane” people who perpetrated a legally punishable offense and a psychologically proficient individual who committed such an act (Gallagher, 2002). This rule was a result from an 1843 case tried in England which related to a

Scottish individual, Daniel M’Naghten, and the accusation raised against him of murdering the secretary to Sir Robert Peel, Edward Drummond (Deutsch, 1946). M’Naghten was impelled by his psychological delusion that Tories were out to get him; nine physicians attested to M’Naghten’s insanity and he was acquitted (Brody & Englehardt, 1980). Queen Victoria of England, however, was quite disappointed by the verdict and retaliated by establishing a committee tasked with reappraising the case (Gallagher, 2002). Those 15 judges soon established the M’Naghten Rule, which necessitated that a minimum of one of the following two criteria be fulfilled in establishing mental insanity: there has to be perplexity in the character of the act committed (i.e. the individual thinking his murder victim is an animal) and the individual is not capable of comprehending the illegality or the incorrectness of the nature of the act (Deutsch, 1946). Of course, the second part of this rule may lead to further confusion. For instance, there are mentally deranged people who understand the wrongfulness of their acts but do not necessarily concern themselves or are not bothered by the morality of their acts because they do not have a conscience (Gallagher, 2002). As a result, under the M’Naghten Rule, these individuals are sent to prison rather than a mental institution where they might be rehabilitated. Of course, studies have also revealed that those individuals who lack a conscience are very rarely capable of rehabilitation. An example would be sexual predators and those suffering from anti-personality disorders (Gallagher, 2002).

The basis of the M’Naghten Rule is that every individual is assumed to be mentally sane unless proven otherwise (Deutsch, 1946). To successfully establish a defense based on insanity, the defendant’s legal team has to provide evidence that in the instance in which the individual was committing the criminal act, the individual was “laboriously under such a defect of reason as not to know the nature and quality of the act he [or she] was doing, or if he [or she] did know it

as not to know that what he [or she]was doing was wrong” (Ellsworth, 1980). Another test of insanity is irresistible impulse (Deutsch, 1946). Developed in 1887, this test is always used in juxtaposition with M’Naghten’s test (Brody & Engelhardt, 1980). In this case, defendants may not be held liable for the criminal act if they have lost the ability and self-control to stop themselves from committing the act, even if they possesses the knowledge that the act was wrong, as required by M’Naghten’s Rule (Ellsworth,1980)). Of course, one of the governing principles of this ruling is that the individual must have been induced into a homicidal and violent rage as a result of a brain anomaly (Gallagher, 2002). It should be noted that this standard of insanity is not widely utilized today because of the dilemma of distinguishing overwhelming and compulsive impulse due to brain anomaly from the impulsivity caused by a liable self-desire to do wrong (Brody & Engelhardt, 1980). In legal instances where a culpable homicide occurs due to a neurological abnormality, such as a seizure, it would stand to reason that the individual would be exonerated (Gallagher, 2002).

By the late 1930s, the mentally insane were legally distinguished and categorized into three groups: the criminally insane, the insane criminal, and the dangerous insane (Deutsch, 1946). The criminal insane category was comprised of those individuals whose violent tendencies were a result of their mental illness (Deutsch, 1946). Meanwhile the insane criminals were the individuals who developed a mental disorder as a result of their incarceration (Deutsch, 1946). The dangerous insane were those individuals who did not previously commit any crimes but were thought to be capable of committing crimes (Deutsch, 1946). It should be noted that there was no clear distinguishing factor between the insane criminal and the criminally insane as the two terms began to be used interchangeably (Gallagher, 2002).

As a result of the disagreement over the completeness and overall twentieth century applicability of the M’Naghten and Irresistible Impulse Rules, in 1954 the United States Court of Appeals established the Durham Product Rule in a ruling between *Durham v. United States* (Ellsworth, 1980). Judge David Bazelon originated the use of this test to measure insanity (Gallagher, 2002). He thought that the previous two tests of insanity left no room to use scientific erudition and therefore came up with this test in which offenders are not legally liable for their unlawful acts if the act was a result of “mental disease or mental defect” (Ellsworth, 1980, p. 105). This ruling also drew some criticisms because even though it was created to increase the involvement of psychiatric attestation, it really created more confusion as a result of the ambiguity of the terms “mental disease” and “defect” since neither terms were further elaborated upon or expounded (Brody & Englehardt, 1980). As a result, if any of these issues were brought up in court each testifying psychiatric professional would have been able to defend his own definition of these terms (Gallagher, 2002). Prior to the generation of this test, however, an individual could potentially be found guilty if the person suffered from mental illness (Ellsworth, 1980).

The most recent of any of these rules regarding the insanity defense is the American Law Institute Rule, which was established in the late 1960s by the American Law Institute as a supplement to its Moral Penal Code (Gallagher, 2002). Per this rule, offenders can be held legally liable for criminal acts if they cannot distinguish between right and wrong *or* had lost power to control themselves so as not to be able to refrain themselves from committing the act due to a mental disease at the time that the act was being committed (Ellsworth, 1980). In its original wording this rule stipulated that “a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he [or she] lacks substantial

capacity to appreciate the criminality (wrongfulness) of his [or her] conduct or to conform his [or her] conduct to the requirements of the law” (Gallagher, 2002, p. 29). This rule ensured it was generally understood that ‘mental disease or defect’ did not excuse recurring criminal behavior (Brody & Englehardt, 1980). The American Law Institute Rule basically included many of the finer points of the previous rulings but it also freed the criteria for the basis of the insanity defense: while the “conformity of conduct” standard is reflective of the irresistible impulse, the “appreciation of criminality” is representative of the “wrongfulness” of the M’Naghten Rule, and the “mental disease or defect” allows for the criterion of the Durham Product Rule (Gallagher, 2002).

In order to help the mentally ill, in 1978 the New York State Department of Mental Hygiene generated the diminished capacity test. By utilizing this test the defendant’s legal representation may prove that the defendant suffered from a mental defect so as to decrease the crime to a lesser offense, thereby reducing the amount of time spent by the accused in prison (Ellsworth, 1980). It should be noted that the basic assumption of all of these rules and tests is that mental disease or defect has altered the individuals’ behavior and caused them to lose control over themselves so that essentially a common jury will decide if the individuals truly suffered from a mental illness which caused them to act in a legally and morally deplorable manner (Ellsworth, 1980).

Despite these laws regarding the mentally ill and their role in the criminal justice system, by the end of the first half of the twentieth century mental illness could not be used as grounds for excusing criminal behavior and as a result, it did not exculpate an individual from criminal liability (Ellsworth, 1980). Section 1120 of the New York State Penal law promulgated that individuals could not be absolved from criminal responsibility as insane individuals if proof was

not provided that they were suffering from a deficiency in logic which would prevent them from understanding not only what they were doing but also that the act they were committing was in fact ethically and morally wrong (Deutsch, 1946). Heinrich Oppen outlined the canonic fundamental aspects of all such criminal trials debating the mental health of the defendant by stating that at first, everyone is assumed to be sane and even if they are proven to be otherwise, they must still live up to the touchstones of the law (Deutsch, 1946).

With respect to criminal trials concerning the mentally ill, though most states enacted legislation that allowed the courts to appoint experts, there was no set process adopted by all the states as to the mental examination of a defendant to ascertain his insanity (Deutsch, 1946). Generally, in the 1930s if a plea of insanity was made in Louisiana, the judge would notify the Commission of Lunacy, which included the parish coroner and the superintendents of the two state hospitals (Deutsch, 1946). In other states, the issue of insanity would be decided before other issues but in California, the issue of insanity was tried after a verdict was reached regarding other issues on which the defendant was being taken to court (Deutsch, 1946). Yet in some other states, prior legislation asserted that a panel of physicians be commissioned to determine insanity (Deutsch, 1946). This committee would only act as counsel to the court but the final decision lay with the court or jury, depending on whether the case was a misdemeanor or felony case (Deutsch, 1946). Meanwhile, a number of other states had laws in place that would allow them to consign the defendant to a mental institution, usually for a month, to determine insanity (Deutsch, 1946).

Many psychiatrists raised countless objections to the idea that judgment on whether an individual really was insane was usually left to the jury to decide (Deutsch, 1946). It would be extremely optimistic to expect that in 1938 a jury, composed of individuals who were most likely

not trained in the understanding of the complicated association between mental illness and to what extent it influenced someone's judgment, to pass the correct judgment (Deutsch, 1946). It should also be noted that these individuals probably also held their own personal stereotypes against the mentally ill (Deutsch, 1946). To illustrate how useless it was to allow the jury to make this judgment, consider the 1927 Remus murder trial. Remus represented himself and testimony from psychiatrists had declared him sane (Deutsch, 1946). Remus, however, took the emotional route to the jury's hearts by giving a poignant closing statement and bade the jury a Merry Christmas (Deutsch, 1946). He was exonerated from guilt and admitted into a mental institution but was subsequently discharged a few months later (Deutsch, 1946). "A member of the jury is reported to have explained the verdict in this wise: 'He [Remus] did not have any Christmas last year, and we wanted to see him have one this year'" (Deutsch, 1946, p. 401).

A few states also passed legislation vis-à-vis several court cases that it was permissible for the court to deem a defendant half-insane if he could not be declared fully-insane, such that that restricted liability would fall on him for the crime he committed. It would therefore allow the individual to receive a lesser or reduced sentence (Deutsch, 1946).

By the first half of the twentieth century, all states with the exception of four had stipulations in place regarding the mentally ill who had been acquitted based on a plea of mental irresponsibility (Deutsch, 1946). These individuals, though spared from going to prison, were committed compulsorily to a mental facility with the provision that further inquiry into their mental state was not necessary for commitment (Deutsch, 1946). If a court delivered a "not guilty" verdict by virtue of an insanity plea, the court had the authority to commit the individual to a mental institution if it determined that the individual truly was insane and a danger to self or others (Deutsch, 1946). All the states had the law that the individual committed to a mental

institution on the plea of mental irresponsibility could be released from said institution if a third party, such as the superintendent of the institution, the board members of the institution, or the court provided grounds for their release—stating that the individual has recovered from their mental issues (Deutsch, 1946). Suffice it to say that the law in the first half of the twentieth century was mainly concerned with punishment and the prevention of criminal acts by the mentally ill (Deutsch, 1946). Care and treatment for the mentally ill was often secondary and not considered very important (Deutsch, 1946). Therefore in the first half of the twentieth century, it would be safe to say that the law was not especially interested in identifying insanity as an affliction or medical disease but rather the legal ramifications of the crime committed. Essentially, the law was interested only in finding out if the mental derangement of the alleged perpetrator extended to the degree that he was mentally compromised and could not be held legally responsible for the criminal acts he allegedly committed. As a result, it is reasonable to assume that cases involving mental responsibility worked to understand how an individual's mental defects or disease extended to impinge on that responsibility. Therefore one comes under the impression that the law was more interested in mental capacity to determine punishment and not necessarily in the well-being of individuals to provide them with the care and treatment that they needed in order to overcome their illness so as to be able to become fully-functioning and contributing members of society (Deutsch, 1946).

By the first half of the twentieth century, commitment laws were not in favor of the mentally ill. The first step in the commitment process involved a petition that was filed by an individual(s) associated with the suspected mentally ill individual (Deutsch, 1946). It was generally required that at least two physicians attest to the mental insanity of the individual to be committed by signing a certificate stating thus (Deutsch, 1946). A legal notice was only

provided to the individual accused of being mentally ill if the judge did not think it would be unproductive and pointless to the proceedings (Deutsch, 1946). The legal notice was not utilized if the judge thought it would prove to have adverse effects on the mental health of the allegedly insane individual (Deutsch, 1946). The question of insanity was then addressed by a hearing in court. Though some states did not require a hearing so as to save the individual from enduring an embarrassing and potentially painful procedure, a jury trial could be asked for by the individual or a relative of the individual (Deutsch, 1946). The commitment procedure did require a medical examination of the individual by a court-appointed physician, with some states requiring that two independent physicians conduct the examination (Deutsch, 1946). Some hearings also involved testimony from a psychologist, a lawyer, or a respected local individual (Deutsch, 1946). If an insanity verdict was passed by a jury, a commission, or a judge, the court then proceeded to authorize the commitment of the individual to either a public or private mental institution (Deutsch, 1946). In some instances, a relative or friend was given charge of the insane individual (Deutsch, 1946). Paying for the costs of transferring an individual from his home to his place of commitment was usually the responsibility of the town or city where the individual resided (Deutsch, 1946). Other times that cost was borne by the patient or relatives of the patient if they had the financial means to do so (Deutsch, 1946). Needless to say, the commitment process was a long, and humiliating, one for patients who needed to be committed. Some states, however, did have laws in place for the temporary or emergency commitment of those severely mentally ill individuals who needed to be committed—though that commitment only lasted from approximately ten days to a month (Deutsch, 1946).

The situation of the mentally ill with respect to commitment laws began to change in the late 1960s and 1970s (Gallagher, 2002). It was during this time period that, encouraged by their

success in the civil rights movement, many justice-seeking individuals and groups began to focus their attention on other such voiceless entities such as the mentally ill, and began to speak out for them (Frank & Glied, 2006). Many court decisions mandated that the mentally ill be active agents in their treatment and commitment choices so that they would not be subject to decisions without their approval (Frank & Glied, 2006). As a result, mentally ill patients were further liberated from any restraints society could possibly try to impose on them (Brody & Englehardt, 1980). The Lanterman-Petris-Short Act or California Community Mental Health Services Act, passed in 1969, curtailed involuntary commitment to 17 days, unless the patient was proven to be an impending assaultive threat (Frank & Glied, 2006). In such a case, however, the stay would be extended for an additional three months (Torrey, 2008). This act was fueled by the anti-psychiatric and anti-mental illness wave that swept the nation in the early 1900s and escalated during the 1950s and 1960s (Torrey, 2008). The obvious issue with this law is that dangerousness is not always predictable. With laws such as these, individuals who could become potentially dangerous were released into society (Frank & Glied, 2006). An example is Herb Mullin, a schizophrenic patient who had been discharged multiple times because of the LPS Act and who proceeded to kill 13 people before he was caught and tried in 1973 (Torrey, 2008). His plea of insanity proved futile and the jury found him guilty of ten murders, thereby leading to a life sentence of imprisonment (Torrey, 2008). Their reasoning: Mullin had been discharged five times from California mental hospitals and after his last discharge, he killed 13 people, who was to say that he would not be discharged into the community again and commit the same acts again (Torrey, 2008)? The LPS Act played a large role in the increasing number of mentally ill individuals who were discharged from mental institutions (Frank & Glied, 2006). Unfortunately, some of these individuals went on to commit crimes and had to be incarcerated

(Torrey, 2008). Mental health care and commitment laws in California have utterly failed, in part due to the LPS Act, to such an extent that Frank Lanterman (the *L* in LPS) himself asked for the law to be changed (Torrey, 2008).

When two young lawyer, Robert Blondis and Thomas Dixon, were appointed public defenders for Alberta Lessard, a paranoid schizophrenic who had been compulsorily committed, they decided to go big and filed a class action suit on behalf of everyone who had been involuntarily committed (Torrey, 2008). This led to the *Lessard* decision in 1972, which rendered civil commitment legislation in Wisconsin unconstitutional and required that involuntary commitment only be used as a last resort when evidence of imminent dangerous to self and others had been established beyond reasonable doubt (Torrey, 2008). The *Lessard* decision had “essentially reversed seven hundred years of English civil law that established the government’s responsibility to protect individuals who are unable to protect themselves, the principle of *parens patriae*. Of course, the *Lessard* decision regarded mentally ill patients as individuals who were qualified and capable of deciding whether they needed treatment or not” (Torrey, 2008, p. 82). As it may be obvious, establishing “dangerousness” is a complex task because if an individual is taking medication in a psychiatric facility, it would be easy to assume that the patient will continually take their medication. That is hard to enforce after the individual is discharged, especially with the disorganized follow-up care system that takes effect after an individual leaves a mental institution (Frank & Glied, 2006). Alberta Lessard herself is suffering as a result of the *Lessard* decision; she still suffers from schizophrenia, lives on Social Security Disability Insurance, and has endured periods of homelessness, as well as been charged with crimes, such as theft and disorderly conduct, as a result of her schizophrenia (Torrey, 2008).

By the 1970s and 1980s state legislations necessitated that individuals found not guilty with insanity as the major factor should be compulsorily committed to mental institutions (Ellsworth, 1980). By the 1970s individuals in Massachusetts found innocent by reason of insanity were sent to the Hospital for the Criminally Insane, which was a subsidiary of the Department of Corrections, not the Department of Health, which would deal with the civilly insane (Ellsworth, 1980). In general, the criminally insane were sentenced to a lifetime of commitment to mental institutions, which in the 1970s had a reputation as having living conditions worse than prisons (Ellsworth, 1980). In fact, a documentary film highlighting the cruel living conditions of the Hospital for the Criminally Insane, titled *Titicut Follies*, was released in 1967 (Ellsworth, 1980). The film showcased a comparison of the mental institution with a maximum security prison, with the institution coming out the loser (Ellsworth, 1980). The comparison revealed that the incarcerated in the prison lived a comparably better life than the committed, as their living conditions were far superior to those of the Hospital and the staff at the prison was more attentive to the needs of the imprisoned (Ellsworth, 1980). As a result, it is not surprising that the insanity defense was rarely used. Utilizing the defense could result in the offender being committed to horrid living conditions for the rest of their life whereas if they had not utilized the defense, the punishment for alleged crime would only result in a brief period of imprisonment in jails with much better living conditions (Frank & Glied, 2006).

By the 1980s the courts required hearings after a verdict of innocence by reason of insanity to ascertain the offender's mental condition so as to determine the length of commitment, if commitment was at all necessary (Ellsworth, 1980). Court rulings also decided that a defendant could not be committed for life but that there would be periodic tests of the defendant's mental status to determine whether further commitment was necessary (Gallagher,

2002). At the same time, mental institutions had to provide beyond just the basic tutelary care of the committed but in fact, also had to provide treatment for those compulsorily committed (Ellsworth, 1980). Many states have a one-year involuntary commitment procedure after an individual has been found not guilty by reason of insanity, after which period the defendant is further tested by psychiatrists to ensure that he is not a danger to self and others before releasing him (Ellsworth, 1986).

The insanity defense has not been used as much as the contention regarding it would suggest (Gallagher, 2002). The mass media especially publicize cases which hinge on the insanity defense—for example, the John Hinckley or the Jeffrey Dahmer cases—which polarizes the public and draws ire and criticism on whether mental ill-health may be utilized as exculpation for illegal acts of murder or other such heinous crimes (Gallagher, 2002). Some also begin to question why mental institutions are used as warehouses for criminally violent or otherwise perilous individuals who are not capable of being healed of their dangerous tendencies (Gallagher, 2002). The truth, however, is that the insanity defense is not easy to pull off and that is why defense lawyers use it as a last resort. According to Gallagher (2006), many states have also significantly reduced the allowed use of the insanity defense.

The Stigma Associated with Mental Illness

The ancient Greeks utilized the term “stigma” to refer to a manifestly physical sign on a person which attested to a negative aspect of an individual’s value or worth (Gallagher, 2002). Presently “stigma” is a term which pertains to the “disgrace itself” rather than the presence of any physical evidence of it on the individual (Gallagher, 2002). Some claim that those “People who are or were mentally ill are stigmatized because they are deeply discredited for their failure to live up to societal expectations and are frequently rebuffed whenever they attempt social

intercourse” (Gallagher, 2002, p. 302). This begs the question: why has mental illness been so disposed to stigmatization? The reasons for it vary but one outstanding factor in this stigmatization is fear (Gallagher, 2002). Mental illness produces fear in individuals who are not familiar with it or who do not understand it. As a result, when the media widely publicize the rare but violent incidents perpetrated by someone labeled as “mentally ill,” it serves to increase public perception of mental illness as dangerous (Corrigan et al., 2011). Obviously psychopaths such as Charles Manson are mentally unbalanced in some way. It should also be clear, however, that they do not truly represent how mentally ill people typically cogitate and behave. When violent acts committed by the mentally ill are publicized by the media, it produces a public perception of “crazy” people as those who rant, murder, and rape whoever happens to cross them at the wrong time (Corrigan et al., 2011). This is a highly subjective and prejudiced view of mentally ill individuals that completely contradicts the objective view or reality pertaining to those suffering from mental afflictions; that is, mentally ill persons are usually not violent or dangerous (Gallagher, 2002).

Another major reason for the stigma and injustices that are heaped on the mentally ill is that mental illness is traditionally thought to result in the loss of logic and reason, which are the requirements for being considered a wholesome human being (Ellsworth, 1980). Without these staples of humanity, people begin to perceive the mentally ill as something less than human. There is also a common misconception that mental illness is irresponsive to treatment, which results in the belief that the mentally ill are not capable of benefiting the society and as a result, useless (Gallagher, 2002). Taken to the extreme, this view may also lead some to conclude that they should be removed completely from society (Callard et al., 2012). The late eighteenth and early nineteenth century gave rise to the eugenics movement (Ellsworth, 1980). The eugenics

were devoted to enhancing the genetic nature of the American population by impeding the additional reproduction of objectionable or unwanted groups, such as the mentally ill, by means of sterilization (Grob, 1983). By 1940, at least 30 states had passed legislation that prevented the mentally ill from procreating (Deutsch, 1946). Consider the horrifying fact that from 1907 to 1940, approximately 18,552 mentally ill individuals had been sterilized (Deutsch, 1946). Even amongst psychiatrists, there was no clear consensus as to the desirability of sterilization, with some voicing concerns against it and others fully supporting it (Deutsch, 1946). This further demonstrates and speaks to the lack of knowledge about mental illness to the extent that psychiatrists could not even agree about the factor of heredity in mental illness.

As it has been stated before, the social stigma, and negative and destructive stereotypes and perceptions of the mentally ill have mainly been created by the mass media (Gallagher, 2002). The mass media strengthen the traditional and ignorant perspective of mental illness by reporting and highly publicizing stories in which the mentally ill have acted in a violent way when in fact, many ex-mental patients are less inclined to act in a destructive way or perpetrate a legal crime than those individuals who have never been diagnosed as mentally ill (Gallagher, 2002). Yet all the news media care about are ratings. After all, mental patients who assault unassuming citizens make for more sensational news than ex-patients who have assimilated into society and who lead quiet and dignified lives (Gallagher, 2002). One notices that the media harp on the psychiatric past of ex-patients while the non-psychiatric past of most criminals is handily disregarded (Gallagher, 2002).

Unfortunately, the media has a profound effect on the opinions embodied by the general public. This is evidenced by the fact that negative stereotypes created by the media of the mentally ill have been especially difficult to modify after years of prejudiced reporting by the

media (Gallagher, 2002). In 1995, at the very end of the twentieth century, Otto Wahl published an insightful book on stigma called *Media Madness*. Throughout his research, Wahl discovered that approximately 70% to 80% of the time, the media depict individuals suffering from mental illness as violent, bizarre, and fear-inducing (Corrigan et al., 2011). This suggests that not much has changed when it comes to the media's portrayal of the mentally ill. Stereotypes about the mentally ill are not only perpetuated by the media but also by enterprising individuals and businesses. For instance, in Halloween of 2004, Universal Orlando Theme Parks advertised that they were going to present the most frightening Halloween extravaganza (Corrigan et al., 2011). In their advertising and promotional marketing, they included straitjackets and committal forms for those journalists who were going to be covering the event (Corrigan et al., 2011). In movies, such as *Batman*, the typical movie plotlines portray the confederates of evil as suffering from some sort of mental illness. One of the most offensive things done by enterprising individuals who make money off of the stigma associated with mental illness involves these individuals buying a state hospital in Weston, West Virginia, and going so far as to name it the "Trans-Allegheny Lunatic Asylum" (Corrigan et al., 2011). One of the cheap gimmicks perpetrated in this former hospital allowed individuals to pay for the experience of being exposed to a so-called "dangerous" patient (i.e. an individual dressed up as a mental patient who proceeded to scream at and chase those who came to the hospital (Corrigan et al., 2011).

As a result of the negative portrayal of the mentally ill by the media and/or other individuals, former mental patients have a hard time in their personal and professional lives. Many former patients "Report that the fact of their illness was used as a threat or 'club over their heads,' which blocked communication with friends and family, resulted in feelings of low self-

esteem, and seriously diminished their chances for meaningful employment” (Gallagher, 2002, p. 303).

According to Gallagher, the extent to which an individual is stigmatized is often linked with the outward manifestations of the individual’s affliction (2002). A significant feature includes the austerity of the illness; for instance, the phobic individual is not stigmatized to the same extent that the psychotic individual is (Gallagher, 2002). This difference in degree of stigmatization occurs as a result of the outward physical manifestations of the illness, such that the more severe illnesses are generally accompanied by more violent, tumultuous, or strange behaviors that are thought to be observably more dangerous by others (Gallagher, 2002). Yet another contributing factor in determining the extent of stigma experienced by a mental patient is the type of medical care they previously received (Corrigan et al., 2011). Even though the degree of stigma experienced by an individual visibly declines after he has been discharged from the hospital, studies have revealed that those who were admitted to state mental institutions experienced more stigma than those who had been admitted to private hospitals (Gallagher, 2002). Those who were involuntarily committed also experienced more stigma (Gallagher, 2002). It should be noted, however, that those who needed to be committed were perhaps also exhibiting more visible manifestations of mental illness (Young, 2010).

Despite the fact that there is still stigma associated with mental illness, it should be noted that ignorance regarding mental illness has slowly declined when compared to the decades past. After World War II many efforts have been made, especially by the psychiatric community, to inform the general public about mental illness, thereby hoping to reduce the stigma associated with the disease (Gallagher, 2010). In previous decades, “Fear, stigmatization, and rejection strongly characterized public feeling about the mentally ill” (Gallagher, 2002, p. 304).” The

public's perceptions or beliefs about the mentally ill are segmented into two different positions: there are those who admit that society tends to put a stigma on mental illness and inevitably stigmatize those suffering from mental afflictions and then the second school of thought contends that society generally tends to acknowledge those suffering from mental illness and exhibit sympathy toward them (Gallagher, 2002). The former school of thought is associated with the more traditional and stereotypical view of the mentally ill as strange and assaultive individuals (Gallagher, 2002). The latter attitude is a nexus to the "psychiatric ideology" that perceives the mentally ill as ailing individuals who are capable of being healed and rehabilitated, similar to persons dealing with any other physical maladies (Gallagher, 2002). In fact, studies conducted in the year 2000, though they revealed little modification in public perception, reflect the same trends discussed earlier with respect to public opinion about mental illness (Gallagher, 2002). Many of the studies also revealed that specific factions of the population, such as the younger individuals (especially college students), tend to adopt the psychiatric ideology (Gallagher, 2002). It should be noted, however, that these individuals who do not automatically stigmatize mental patients do not comprise the majority of the public. Of course, the studies also indicated that being exposed to the psychiatric ideology does not necessitate an adherence to the view (Gallagher, 2002). It is also really important to note that some times how people respond to these surveys is not necessarily the way they would actually behave in their daily life (Gallagher, 2002). Yet there is conflict when deciding if those who have come in contact with, or are somehow more knowledgeable about mental illness, are actually more tolerant and do not lean towards stigmatizing the mentally ill. As Gallagher notes, "A sophisticated ideology may not necessarily imply a reduced tendency to stigmatize and tolerate psychopathology because

knowledge is intellectually based, whereas stigmatization is an emotional phenomenon” (2002, p. 306).

The conventional view that allows for the stigmatization of the mentally ill is usually acquired during childhood and is unfortunately strengthened and amplified by the media (Corrigan et al., 2011). Typically the general public does not perceive the mentally ill to be really sick; they are only classified into a category of individuals who are fear-inducing and impervious to a cure (Gallagher, 2002). Many wrongly consider those afflicted with mental illness, and thus distinguish them from those who are “really” physically sick, to be the casualties of their own debilitated natures and bad judgments (Gallagher, 2002). Of course, this unfortunately ignorant perspective is not reflective of all groups of people. In fact, many studies have revealed that social class has a profound effect on perceptions of the mentally ill (Gallagher, 2002). This is because those individuals who are part of a high social class are more likely to be educated and through their education, would have come to realize that mental illness is truly a serious disease that needs to be considered (Gallagher, 2002). Therefore, as the degree of higher education increases, the likelihood that an individual has composed a non-judgmental and more informed perspective of mental illness and mental patients increases (Gallagher, 2002).

Yet the sense of shame associated with mental illness results in those individuals unjustly being deprived of their lawful possibilities available to them in their professional and personal lives—both categories comprising the ways in which a fulfilling life and living is obtained (Corrigan et al., 2011). Many ex-patients also change residences and more to areas where their past as mental patients are not deduced by others, thereby allowing them to evade the stigma felt by those whose psychiatric history is common knowledge (Gallagher, 2002). In fact, it is most common middle class families to move rather than try to put up with the combined pressure of

dealing with the visible manifestations of the ex-patient in the family and knowing that their neighbors are aware of the aberrance present in their ex-patient family member (Gallagher, 2002). Those ex-patients who do not feel stigmatized do not feel this threat because they are probably not open with others about their previous psychiatric history (Gallagher, 2002).

In recent years, population-based stigma programs, such as public service announcements, have become more prominent, especially in the twenty-first century. Public service announcements targeted towards outlining and decreasing the stigma of mental illness are generally exposed to a larger group of people. As a result, they are efficient, to a certain extent, in their original goal (Corrigan et al., 2011). In fact, a well-designed PSA has the potential of having a profound effect on people rethinking their previously-held traditional perspectives on mental illness. Using celebrities and other such influential and publicly visible personalities is one of the best ways to gain attention for a PSA, as exemplified by previous PSAs. An example of a PSA conducted to raise awareness about mental illness is that conducted by Glenn Close, a famous film personality (Corrigan et al., 2011). The PSA included individuals donning white t-shirts. Half the actors' shirts had the name of a mental illness inscribed on their shirts while the name written on the t-shirt of the individuals next to them included relationships, such as "mom," "battle buddy," or "better half" (Corrigan et al., 2011). The PSA, titled "Change a Mind About Mental Illness," was released on October 21, 2009 and proved to be a big success as it exposed many people to mental illness, including those who had either watched it on TV or through other such video-sharing websites as YouTube. Of course, Close was a driving force in the popularity of the campaign as she is an internationally famous personality. Celebrities such as Close have the unique opportunity of being able to reach a wider audience in all corners of the globe.

Apart from large-groups focused PSA there are also individual advocates who tend to make local groups of people or otherwise distinguished and influential individuals their concentrated focal point (Corrigan et al., 2011). Concentrating on influential individuals, whether they are political or not, is really important because even if these individuals are not involved in politics, they can still provide financial aid in either helping those with mental illness or increasing awareness and thereby decreasing the stigma of mental illness.

As one can probably deduce ,after this exhaustive research of the plight of the mentally ill in the United States since the twentieth century, things are certainly better but not as well as they possibly could be. Whereas in the beginning of the twentieth century, the mentally ill were thought to be the degenerates of society and thus often abandoned in public mental institutions the government did not want to spend money on, things began to look up towards the later part of the century and towards the beginning of the twenty-first century (Frank & Glied, 2006). That, however, is not enough to erase the horrific conditions suffered by the mentally ill during the 1900s (Deutsch, 1946). Many public mental institutions suffered from overcrowding and since public mental hospitals were paid for by the state, there was never enough funding available to provide adequate care to the abandoned and destitute of society (Isaac & Armat, 1990). There was even a period of time when theories circulated suggesting that mental illness was not real (Armour, 1989). How could anyone possibly secure funding for a disease that was in contention as actually being a disease? The mentally ill were viewed as deviants and lack of research into the affliction resulted in unforgivable actions, such as the sterilization of the mentally ill (Grob, 1983). Treatment of the mentally ill in public institutions was not only inadequate but completely inhumane (Deutsch, 1946). In fact, a few exposes indicated that the treatment of prisoners, supposedly the bane of society, were far more favorable than the

treatment of the mentally ill (Ellsworth, 1980). Attempts to involve the federal government resulted in Congress passing legislation which would attempt to completely do away with mental asylums but relocate care for the mentally ill to community-based mental health centers vis-à-vis the passage of the Community Mental Health Centers Act in October of 1963 (Isaac & Armat, 1990). These community-based institutions also failed but had more negative far-reaching effects that were not anticipated in congressional hearings (Rochefort, 1989). In effect, this Act along with lawsuits brought against mental hospitals and the passage of Medicaid and Medicare, gave rise to a period of deinstitutionalization. The deinstitutionalization of the four-decade period between the 1950s and the 1970s to early 1980s resulted in many mental patients individuals ending up homeless or plagued by crime (Young, 2010). As evidenced by research, thus far no program had been passed through to allow for adequate follow-up care for those individuals who had left mental hospitals. Some mental patients began to pour into general hospitals to seek mental healthcare that they desperately needed (Reamer, 1989). The law and public policy has also proved most unhelpful with respect to taking care of the mentally ill in this country. There really has not been any new legislation that would keep the mentally ill out of prisons and off the streets and in institutions that would be able to offer the proper care and treatment that these individuals need. There also does not exist any effective measures of making sure that mental patients take their medications, without which they are prone to behaviors that are not only not conducive to the well-being of the individuals themselves but also have the potential of adversely affecting those around the mentally ill individual (Torrey, 2008). Despite the fact that the United States is considered the epitome of civilized, modern, and technologically advanced, many of the mentally ill still live secretly despondent lives, have unmanageable feelings of inconsequentiality or fretfulness, typically cannot manage to hold

down a job as a result of such anxiety, and normally face such personal and social difficulties that it not only bears heavily upon them but on those around them, as well (Gallagher, 2002). Suffice it to say that negative stereotypes of the mentally ill and a lack of understanding of mental illness transgress on efficient care for those afflicted with the disease. Why must these individuals who did not ask for their illness still feel the sting of stigma? Though it is commonplace to read material that preaches change for mental patients, especially changes specifically geared toward reducing stigma, not much has been done.

To deal with the issues discussed it is possible to suggest reform with respect to the care and treatment of the mentally ill and a change in public health policy. The portrayals of mental illness in the media sustain one of the most damaging stigmas about the mentally ill. That is, that mentally ill individuals are strange, violent, and prone to unprovoked violence and therefore should be shunned to prevent injury to unsuspecting bystanders. Stigma has such a stronghold on the mentally ill that some have called the experience a “career” with long-run expectations and impossible hurdles. Only recently have studies found that those individuals who employ the psychiatric ideology—that is, those who have a more tolerant view of the mentally ill—have developed this mindset through higher education (Gallagher, 2002). To further increase this psychiatric ideology in the general public, we should produce more public service announcements through different mediums, including billboards, Twitter, and video PSA on TV, YouTube, and other such media sharing services. The negative portrayal of the mentally ill in the media should be stopped, as it has adverse effects on the mentally ill. There should be more public service announcements and the NIMH should implement policies to increase public awareness of the mentally ill. Since previous research has suggested that negative stigmas about the mentally ill first begin to form in childhood, the state government and schools should work

together to instantiate public education campaigns about mental illness for school-age children. If we work towards decreasing or preventing stigmas from forming as early as possible, then it is possible that the stigmatization of the mentally ill will decrease.

The federal government should decrease the amount of effort, specifically financial effort, it is currently funneling to warfare and take up the task of allotting more funds to improve conditions for the mentally ill in public mental health institutions. The National Institute of Mental Health should dedicate more research to mental illness and perhaps, as a result, come up with more ways for those suffering from mental illness to be able to manage their illness. The NIMH should also conduct research into the most efficient and patient-friendly strategies to operate these mental healthcare facilities. States need to implement policies that allow for public mental institutions to run in the most efficient ways possible. These mental hospitals need to make sure that they hire individuals who are qualified to work with the mentally ill. They also need to make sure that more than one independent healthcare professional, such as a psychiatrist or psychologist, agree on the diagnoses that they assign to patients. Public mental institutions or general hospitals with psychiatric wards should be closely monitored, with unannounced visits from the Joint Commission on Accreditation, Healthcare, and Certification to further aid in the strategy of increasing efficiency and providing humane care. As the research discussed in this thesis has shown, the commitment laws are outdated, with many individuals suffering as a *result* of them when in fact commitment laws should serve to protect the rights of the mentally ill. If a patient needs commitment, more than one qualified psychiatrist or psychologist should independently evaluate them. More states should compel their hospitals to implement assisted outpatient treatment (AOT) programs into their healthcare practicum. The well-being of some mental patients very well depends on them taking their medication. If they are not going to take

their medication, how can they control the symptoms that are not only disruptive to themselves but also to society in general? The mentally ill should not be thrown into prisons and jails like common criminals where their care will suffer with no qualified healthcare professionals to care for them. The government needs to find ways to implement legislation that helps the mentally ill off the streets. One way to get these patients off the streets and out of jails and prisons is to make sure they take their medication, which would be possible with more AOT-like programs, as has been suggested above. Instead of funneling money into the Department of Corrections to care for the mentally ill, the government needs to find ways to bypass those lines and allocate funds so that the mentally ill who are prone to crime can receive the treatment that they need.

The federal government should convene a commission that reports on the current state of mental health care in the United States. The study findings should then be presented to psychiatrists, psychologists, and other healthcare professionals. They should come together in an open forum to discuss the main issues and come up with possible solutions. Then these individuals should subsequently present their findings and possible solutions to lawmakers. The advantage in having these healthcare professionals meet before is that it would reduce the possibility of disagreements rising amongst healthcare professionals in front of Congress. If Congress is presented a clear plan of action, though, of course that may just be wishful thinking, it is possible that healthcare professionals can convince them to not worry so much about budgeting costs but to implement policies and strategies that would provide better mental healthcare for the mentally ill.

This, of course, will take time implement but someone needs to start somewhere. We cannot let the people of this country go to waste; they must be taken care of and allowed to live as functioning and contributing members of society. Mental illness should not be equated to

stupidity or the perception that the mentally ill cannot contribute to society. We cannot afford more instances where the mentally ill are disregarded and ignored like they do not exist. We cannot punish the mentally ill because they are individuals who are suffering from diseases that hold them prisoners.

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