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The State of the Asylum:
Assessing Institutional Legitimacy through an Examination of its Clientele

By

Peter Dranow

Submitted in partial fulfillment
of the requirements for
Honors in the Department of Sociology

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ABSTRACT

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While mental asylums have long been a point of intrigue and folklore in Western culture, they have also been the subject of bitter debate in academic and medical circles. Brought to the forefront of sociology with Erving Goffman's benchmark work, *Asylums; Essays on the Social Situation of Mental Patients and Other Inmates* (1961), the question of whether mental institutions in America were—and are—fundamentally curative or custodial institutions has yielded a dualistic interpretation of the past, present, and future. Whereas the psychiatrist and liberal historian might characterize America's failed asylums as externalities of progress and, in some cases, poor policy, social scientists of the Goffman mold saw asylums as instruments of social control, built to restrain, repress, and pathologize the behavior of deviants. This paper provides both a historical review and a contemporary assessment of mental institutions in America. The former is achieved through an analysis of literature regarding institutional function and legitimacy from the Colonial era to the present day. The latter is achieved empirically through univariate, bivariate, and multivariate analysis of data on demographics and mental health from the Substance Abuse and Mental Health Administration's 2018 Mental Health Client-level Dataset (MH-CLD). Ultimately, this paper suggests that all hope may not be lost for America's asylums; however, improving existing systems of inpatient mental healthcare is no easy task.

TABLE OF CONTENTS

INTRODUCTION	1
CHAPTER 1: HISTORY, BACKGROUND & LITERATURE	2
CHAPTER 2: METHODS	23
CHAPTER 3: RESULTS AND DISCUSSION	28
CHAPTER 4: CONCLUSIONS	45
REFERENCES	55
APPENDIX	61

a·sy·lum

/ə'sɪləm/

noun

1. The protection granted by a nation to someone who has left their native country as a political refugee.
"she applied for asylum and was granted refugee status"
2. **DATED** An institution offering shelter and support to people who are mentally ill.
"he'd been committed to an asylum" (Oxford Languages 2021)

In *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (1997), social historian Edward Shorter remarks, “the history of the asylum is the history of good intentions gone bad.” Though it would be hard to find a discipline further embroiled in controversy than that of which Dr. Shorter speaks, few would disagree with his remark.

Historically, the origin of these “good intentions” can be traced back to the European Enlightenment, when hope, reason, and scientific promise sparked a wave of humanitarianism and sympathy towards the mentally ill. After spreading to America, these sentiments materialized by way of institutionalization and the proliferation of asylums in the 19th and early 20th century. By the 1950s, the condition of U.S. asylums took a turn for the worse. Patient abuse and overcrowding had become widespread, leading many politicians and intellectuals to become critical of asylums. Ultimately, this fueled a successful push to deinstitutionalize America’s mental institutions in favor of community-based care. Since then, the presence of inpatient mental facilities in the U.S. has continued to shrink and privatize.

This paper seeks to bridge gaps between historical periods, narratives, and stakeholders to offer a sober assessment of what’s left of America’s mental institutions and what should be done with them going forward. Specifically, current literature is extended by connecting the asylum’s place in American memory with its contemporary status and a profile of the individuals it serves today. Beginning with the history of mental healthcare in the U.S., Chapter 1 establishes a pattern of key events and the dueling interpretations which have dominated popular discourse on these events. Subsequently, Chapter 2 outlines the methodology used to analyze the current state of mental institutions through its clientele. Chapters 3 and 4 describe this paper’s key findings and what they can and cannot tell us about the function and legitimacy of mental asylums today.

CHAPTER 1: HISTORY, BACKGROUND & LITERATURE

When Pennsylvania Hospital was founded in 1751, Philadelphia became the host of America's first hospital. Two years later, a dark and secluded portion of its basement was carved out to make room for what would become the first inpatient mental health program in U.S. history (U.S. National Library of Medicine 2017). While the original program at Pennsylvania Hospital could only be described as crude at best, it was historic and marked the beginning of America's long and unusual relationship with institutional psychiatry. To begin my account of key historical events in this regard, I will begin with the condition of colonial Philadelphia and the problems which led to the construction of Pennsylvania Hospital.

Founded alongside the Delaware River in 1682, Philadelphia quickly became a preferred place of business for traders foreign and domestic and the city acquired status as a hub of immigration, transatlantic commerce, and industrial production in the American colonies (Smith 1977:865). Moreover as enterprise flourished, Philadelphia experienced immense population growth starting in the late 1600s and continuing well into the 18th century; growth which rivaled, and at times surpassed, its largest urban counterparts including New York City, Williamsburg, and Boston. According to the University of Pennsylvania, "the population numbered 11,500 [in 1730] and had grown to 15,000 by 1750 ... by 1776, its 40,000 residents made Philadelphia the second-largest English-speaking city in the British Empire," second only to London (Penn Medicine N.d:1).

While Philadelphia attracted its share of wealthy immigrants, the majority of the city's newcomers were pious, working-class migrants from Eastern Europe. For the latter group, religious freedom and economic opportunity were among the most significant factors driving their decision to travel westward, and while students of U.S. history often remember colonial

settlers, Philadelphians and otherwise, as achieving this much, Smith (1997) suggests this is not the full truth. In “Death and Life in a Colonial Immigrant City,” Smith posits that very few of Philadelphia’s immigrants realized the social mobility they yearned for due to a combination of the problems that immigrated with them and the problems which met them upon their arrival. Regarding the former, a great number of immigrants from Eastern Europe struggled to cope with disabilities, old age, or diseases caught while traveling. Regarding the latter, as a fledgling city, Philadelphia largely lacked the infrastructure needed to care for its growing population throughout the 18th century. While there is not reliable demographic information on Philadelphia’s population until 1790, from Smith’s analysis of primary sources in *Death and Life* (1997:870-889) it is clear that these poor conditions gave way to a variety of social crises, including job shortages, unsafe conditions for living and working, and high rates of mental illness and homelessness (U.S. National Library of Medicine 2017).

Before the founding of Pennsylvania Hospital in 1751, Philadelphia’s mentally ill resided on city streets, almshouses,¹ or in jails, as was the standard practice throughout the U.S. colonies and U.K. at the time. While this may have been sufficient when the city’s population was just a few thousand residents in the late 1600s, as Philadelphia’s population swelled into the tens of thousands in the 1730s, almshouses and jails were becoming overwhelmed and an alarming number of mentally ill individuals were left homeless. By the midpoint of the 18th century, it is estimated that Philadelphia and its Delaware Valley neighbor Baltimore, had the highest rates of homelessness in the American colonies (Kusmer 2002). Speaking of this in *The History of the*

¹In the U.S., almshouses (i.e., poorhouses) were institutions that housed the poor, disabled, and mentally ill. While they were built to provide shelter and work opportunities for the needy, in many cases, they turned into “dumping grounds” for problem populations (i.e., petty criminals, prostitutes, and abandoned children). They remained significant institutions until the early 20th century (Spencer-Wood 2001:117-118)

Pennsylvania Hospital, Thomas Morton remarked, “The want of a hospital located in the city soon came to be seriously felt ... the Almshouse was simply a place of confinement” (1895:5).

The original charge to address homelessness and mental illness in Philadelphia is attributed to two of the most prominent figures in U.S. history and medicine respectively: Benjamin Franklin, quintessential American thought leader and co-author of the Declaration of Independence, and Dr. Thomas Bond, a physician in Philadelphia’s Quaker community who would come to be known as “the father of clinical medicine,” (Morton 1895). While Franklin led the political end of the campaign to create Pennsylvania Hospital, Bond is attributed with the original vision. In his autobiography, Franklin remarked:

In 1751, Dr. Thomas Bond, a particular friend of mine, conceived the idea of establishing a hospital in Philadelphia (a very beneficent design, which has been ascrib'd to me, but was originally his), for the reception and cure of poor sick persons, whether inhabitants of the province or strangers. He was zealous and active in endeavouring to procure subscriptions for it, but the proposal being a novelty in America, and at first not well understood, he met but with small success. (Franklin and Woodworth Pine 1916:219)

After Bond discussed his vision for a provincial hospital in Philadelphia with Franklin, it was decided that Franklin would present the idea to Pennsylvania’s general assembly in the form of a petition² (Franklin 1916). While there were some initial objections to the proposal from Pennsylvania’s rural representatives—out of fear that it would only benefit their urban counterparts—it was ultimately agreed upon that if Franklin and Bond could raise 2,000 pounds, which was undoubtedly a great sum of money at the time, then the assembly would match their funds with an equal amount and grant a charter for Pennsylvania Hospital (Morton 1895).

Unsurprisingly, the pair were savvy fundraisers, and having exceeded the 2,000 pound goal within months of Franklin’s pitch, the colony’s legislative body approved a charter for Pennsylvania Hospital on May 11th, 1751 (Penn Medicine N.d.). After establishing the hospital’s

² In addition to Franklin and Bond, 33 additional signatures were gained in support of their idea before Franklin’s appeal was heard in January 1751 (Morton 1895:5-10).

legitimacy, Franklin, Bond, and colleagues shifted their focus to designing and building the facility. While they spent nearly two years entrenched in this process, the hospital was rendered complete and the facility admitted its first patients on February, 11, 1753 (U.S. National Library of Medicine 2017).

While Philadelphia was unique from other urban centers in the U.S. colonies—insofar as the city’s demographic makeup and outsized contribution to the history of mental asylums in the U.S— the problems which led to the founding of Pennsylvania Hospital were not. Rather, they reflected the common problems faced by fledgeling cities in the colonies, problems of which prompted the construction of hospitals with increasing pace in the century to come (Penn Medicine N.d.).

Insanity Under Colonial Law and America’s First Public Asylum

While Pennsylvania Hospital is widely regarded as the home of America’s first inpatient mental health program, it is not considered as the country’s first “asylum” as its ward for mentally ill patients was connected to the general hospital and not a facility of its own (Penn Medicine N.d.). Rather, the first institution founded exclusively for treating mental illness in the U.S. was Eastern State Hospital,³ a small public institution located in the suburbs of Williamsburg (Commonwealth of Virginia N.d.). Like Philadelphia, Williamsburg, and Virginia as a whole, spent much of the 18th century attempting to maintain order alongside a growing population and alarming rates of homelessness and mental illness therein.

Prior to the founding of Eastern State Hospital, colonial officials and constituents in Virginia had unique exposure to the issues caused by mental illness in their community. Dating

³ Formerly known as the Eastern State Lunatic Asylum, and not to be confused with the Eastern State Hospital founded in Spokane County, Washington in 1891 (Bjerken 2019:7-12).

back to Virginia's founding, the colony's judicial system, and especially its criminal courts, served as a vessel for citizens to engage in discussions about mental illness and its effect on human behavior. This was the result of Virginia's first judges and legislators' decision to adopt statutes from British law concerning the mental capacity of defendants in criminal proceedings—a decision that was uncommon for legal scholars in the U.S. colonies who were increasingly driven to stray from the precedents of their mother country and instead incorporate new ideas about what law and society meant to American settlers (Rankin 1964).

While the legal precedents Virginia's courts adopted from Britain concerning mentally ill individuals were not exactly benevolent, they were empathetic to the impulsivity and criminal activity that was associated with "lunacy" at the time. This much is collectively acknowledged in Rankin (1964), Morgan (1987), and Clemente (2015), all of which cite Virginia's judicial system to have functioned both as an institution of social control over deviant populations, the mentally ill included, and an avenue of which they could receive validation and resources depending on the reason for their appearance in court (Morgan 1987:453-458). However, despite the Virginia court system's reputation for harsh punishments, stringent rulings against moral offenses,⁴ and the more than occasional relegation of mentally disordered individuals to the public gaol in Williamsburg, according to Michael Clemente's 2015 article "Reassessment of Common Law Protections for 'Idiots'" (2015:2749-2750), its treatment of mental illness was generally more nuanced and less brutish than it is given credit for.

⁴ Provisions for the prosecution of "Moral offenses" were largely used to punish behaviors that were perceived to oppose Evangelical values, such as sexual promiscuity, bastardy, and absences from church. The judicial system's handling of these types of offenses were the subject of increasing criticism in the late 1700s amidst growing secularization in the American colonies at the time. (Morgan 1987:469-470)

Clemente (2015) highlights considerable protections⁵ that were afforded to mentally ill and disabled individuals, distinguished under colonial law as “lunatics” and “idiots” respectively, with the latter (i.e., the mentally disabled) having recieved especially comprehensive safeguards including an exemption from capital punishment and prosecution for certain lesser crimes. Clemente’s relatively favorable account of Virginia’s jurisprudence in this regard largely echoes the sentiments contained in Morgan (1987), which expands on the role played by grand juries in pre-revolutionary Virginia which were instructed to not only judge a “lunatic’s” alleged offense, but also the character of their psychological troubles and their reputation in the community (Morgan 1987). Gwenda Morgan’s article also suggests that Virginia’s judicial system did more than dictate the guilt or innocence of mentally disordered individuals. For example, in cases of lesser crimes involving a homeless mentally ill person, Gwenda cites that grand juries often leveraged their power to place the accused in the care of an almshouse or family member. Subsequently, when Virginia’s court system shifted its focus to ruling on matters pertaining to taxation, labor, and intercolonial commerce at the midway point of the 18th century, the need for a system devoted to housing and caring for the mentally ill became especially pronounced and at least one government official took notice (Gwenda 1987).

The idea to build a psychiatric hospital in Williamsburg was first proposed in 1766 during the annual gubernatorial address to Virginia’s House of Burgesses by Francis Fauquier (1703-1768), an ardent supporter of enlightenment-era humanitarianism and Virginia’s lieutenant governor at the time (Hatzenbuehler 2014; Hamilton, Butters & Gilbertson 1961). In his speech, Fauquier inquired:

⁵ It should be noted that Clemente’s 2015 article, which has been the subject of much praise from legal theorists, argues that legal protections for the mentally disabled in America were never stronger than they were during the pre-revolutionary period. Further, Clemente cites these protections to have been significantly diminished by the Constitution and the ratification of the 8th Amendment specifically.

It is expected I should also recommend to your consideration and humanity, a poor, unhappy set of people, who are deprived of their senses and wander about the country terrifying the rest of their fellow creatures. A legal confinement and proper provision ought to be appointed for these miserable objects (Hamilton, Butters & Gilbertson 1961:69).

While Fauquier's speech intrigued several of his fellow legislators and seemed timely given the court system's diminished capacity to rule on matters regarding the mentally ill, it did not prompt any direct action from the House of Burgesses (Hamilton, Butters & Gilbertson 1961). However, after the colony's lawmakers were called to order again regarding the issue of mental illness in 1770, they resolved to give Fauquier's strategy a try, ordering "that a hospital be erected for the reception of persons who are so unhappy as to be deprived of their reason" (Hamilton, Butters & Gilbertson 1961:69). The construction of Eastern State Hospital in the suburbs of Williamsburg was completed less than three years later and on October 12th 1773, the facility admitted its first patients and earned the distinction of America's first public mental asylum (Commonwealth of Virginia N.d.).

After Eastern State Hospital was founded, only two more inpatient mental health programs were opened before the turn of the century; New York Hospital's Ward for the Curable Insane, founded 1792 addendum to New York Hospital's general practice, and Spring Grove State Hospital, founded in 1797 as a stand alone psychiatric facility in Catonsville, Maryland (Shorter 1997:35). Each closely resembled one of its predecessors, New York Hospital's inpatient program modeling itself after Pennsylvania Hospital's and Spring Grove after Eastern State.

European Influences, Shifting Paradigms, and the Rise of 'Moral Treatment'

While the influence of British legal precedent on colonial judicial practices was profound, it was just one of the myriad of ways scholarship from Enlightenment-era Europe was shaping societal institutions in the colonies. This section will focus on what is widely considered by historians, psychiatrists, and sociologists alike to be the most significant contribution from the Age of Enlightenment in Europe to the roots of institutional psychiatry in America: the ‘moral treatment’ model of institutional care—attributed, in principal, to Parisian Psychiatrist Philippe Pinel.

In *A History of Psychiatry* (Shorter 1997), Edward Shorter argues that, although mental illness has long been a subject of human inquiry and scientific intrigue, psychiatry—both as an academic discipline and sub practice of medicine—did not begin until the end of the 18th century,⁶ contemporary with the apex of Philippe Pinel’s career. According to Shorter (1997:10-15), the Frenchman’s first significant experience in treating the mentally ill—one which he gained, in part, due to the shortage of doctors in post-revolutionary France—came during his tenure as chief physician at the Hôpital Bicêtre in Paris from 1792-1794. Hôpital Bicêtre, Pinel became the Director at Salpêtrière

Shorter cites Pinel’s ascent of the medical establishment in post-revolutionary France to have been accelerated by his tenure as chief physician at the Hôpital Bicêtre in Paris from 1792-1794 and trio of subsequent publications: *Nosographie philosophique*, *Recherches et observations sur le traitement moral des aliénés*, and *Traité médico-philosophique sur l’aliénation mentale, ou La manie* published in 1798, 1799, and 1801 respectively (Woods and Carlson 1961).

⁶ Some historians have argued an Italian physician by the name of Vincencio Chiarugi (1759-1820) deserves many of the distinctions bestowed upon his French predecessor (e.g., founding modern psychiatry and first conceptualizing moral treatment). However, according to Shorter, the Chiarugi camp sits squarely in the minority as most recognize Pinel outshined the Italian in both the significance of his scholarship and the real-world experience he had in shaping the treatment of the mentally ill (Shorter 1997:10-15).

Pinel's belief structure surrounding mental illness and the mentally ill, as expressed in his three benchmark works, to be summarized as the following: mental illnesses are not permanent, they vary in cause and presentation, and, with *traitement moral* (i.e., holistic, individualized, and scientifically-oriented care), it is possible to ameliorate their symptoms and turn the subjects of their hindrance back into productive members of society (Pinel 1798, 1799 & 1801; Digby 1983; Woods & Carlson 1961:14-25). Moreover, based on Pinel's tenure as chief physician, first, at the Hôpital Bicêtre and, later, at Salpêtrière—both of which being single-sex asylums located in Paris, the former providing care for men and the latter for women—he concluded that inpatient mental asylums were optimal settings for the rehabilitation of the psychologically troubled (Pinel 1801:48).

Without discrediting Pinel's accomplishments, Dr. Anne Digby, author of the 1983 paper "Changes in the Asylum," argues that while Pinel's coinage of the term, 'moral treatment,' was original, the humanitarian framework of his concept and progressive attitude towards treating the mentally ill was not. To this end, Digby explains that Pinel was almost certainly inspired by scholarship from some of the European Enlightenment's earliest, and most prominent figures, most notably including John Locke, philosopher, political theorist, and champion of associationist psychology. In an analysis of Locke's work as it pertains to the foundations of moral treatment, Digby (1987) remarks:

The associationist psychology of John Locke was important in suggesting that madmen "do not appear to . . . have lost the faculty of reasoning". Rather "madmen put wrong ideas together, and so make wrong propositions, but argue and reason right from them." These wrong connections had such great force as "to set us awry in our actions." Psychiatric writing in England during the eighteenth century showed an increasing concern to eradicate erroneous habits of thinking, through the knowledge that the physician acquired of the individual patient and the authority which he exercised over him. This emphasis on the importance of the individual case history differed markedly from the indiscriminate medical treatments outlined above. Instead it was thought that the anti-social actions of the madman could be controlled through judicious management. (John Locke as quoted in Digby 1983:221)

Locke's words, as analyzed by Digby, provide a useful roadmap for understanding not only the aforementioned philosophical elements of Pinel's assertions but also his practical ideas for the implementation of moral treatment in institutional psychiatry—his foremost contribution to shaping the future of asylums in throughout Europe and the U.S., and the final aspect of his profile that will be treated in this section.

Pinel's vision for institutional psychiatry rejected several prominent ideas about mental illness from the 18th century; two of the most significant being the pious view of madness as a product of demonic possession and the idea that the best way to handle lunatics was by maintaining their custody in isolation from the rest of society (i.e., the custodial approach) (Digby 1983). By Pinel's time, the custodial approach had become standard practice in Europe, and the mentally ill had been habitually detained in madhouses, dungeons, and prisons dating back to the middle ages. Besides their relegation to squalid facilities, individuals with psychological troubles had their freedom further deprived through the liberal use of chains, straitjackets, and metal restraints in these facilities (Shorter 1997).

While some European communes neglected the mentally ill due to a genuine lack of resources, this was the exception as most places embraced the custodial approach wholeheartedly by the outset of the 18th century as it went hand in hand with the pious interpretation of insanity propagated by the Christian church and spiritual leaders throughout the middle ages. Those who subscribed to this belief testified that mental illness was caused by demonic possession. Moreover, those who were possessed with madness were best left in squalor; a point famously decreed by influential British poet, devout Christian, and Enlightenment-era tastemaker, Alexander Pope. In one of his most famous books, *An Essay on Man*, Pope reasons: "What thin partitions sense from thought divide!" There was thus only a short distance from men to brutes,

and the insane were seen to be on the borderline of animal life and hence impervious to cold, discomfort, and hunger” (Digby 1983:220-221).

In the *Traité médico-philosophique sur l'aliénation mentale*,⁷ Phillippe Pinel’s most famous paper and what many consider his unofficial manifesto to moral treatment, the Frenchman railed against the notion that demonic possession had any relation to the mental illnesses besieging his patients (Pinel 1800:246). Moreover, citing the claim to be baseless and its supporters senseless, Pinel contended this erroneously justified the inhumane treatment of individuals in need of help with their psychological troubles (Ossa-Richardson 2013:553). While Pinel’s work took little time to be implemented on a larger scale, unbeknownst to him at the time, his vision of moral therapy was being put in practice before his book was published (Edington 2013).

Founded in 1792 by British Quaker⁸ William Tuke, the York Retreat (i.e., “The Retreat”), not to be confused with York Asylum, is widely regarded as the first mental institution to have successfully implemented moral treatment into its practice and served as the inspiration for several of America’s first asylums including Bloomingdale Asylum in New York and the ward for lunatics at Pennsylvania Hospital (New York Hospital 1821; Sudak 2017). Following the death of a young girl,⁹ who was also a Quaker, at York Asylum, William Tuke founded the York Retreat under the promise that it would provide sanctuary for the mentally ill, and cruelty towards patients would not be tolerated. Quoted in the September 5th, 1792 edition of *the York Courant*, the asylum’s governors (several of which were Tukes) echoed their founder’s

⁷ Referenced in translation as either *A Treatise on Insanity*, or *A Treatise on the Medical Jurisprudence of Insanity*.

⁸ The British Quaker community was also referred to as “the Society of Friends.” (Edington 2013)

⁹ Hannah Mills, a Leeds Quaker, was admitted to York Asylum for depression-like symptoms on March 15th and died while under the asylum’s care on April 29th 1790. While she was admitted for depression-like symptoms it is unclear what type of treatments she received or what caused her death. Mills’ death was considered especially egregious as her relatives and members of the Quaker community asked to see her in the weeks leading up to her death, given York’s poor reputation, only to have the entirety of their requests denied by the Asylum’s staff. (Digby 1983 223)

sentiments and announced to the public that The Retreat was a place “where the patients might expect to meet with the most humane and disinterested treatment; and where they might have a chance of being restored to their health” (The York Courant in Digby 1983).

For William Tuke, the environment his patients were being treated in was as important as the treatment itself and with help from his family and fellow Quaker John Bevens, Tuke meticulously planned the Retreat to radiate what he described as “cheerfulness” (Edington 2013:10). For the interior, this was done through the use of large skylights, decorative furniture, and uplifting artwork; likewise, for the exterior, Tuke opted for sprawling gardens, elegant architecture, and plenty of space for recreation (See Appendix 1.a). In an undated letter to Bevens around the time of The Retreat’s opening, Tuke wrote:

For tho their minds are disordered many of them have vigorous health bodies, that require exercise to preserve them so, otherwise disorders may be generated by their confinement that might prove more fatal and dangerous than what they were in for--for that reason I have done what I could to increase their length (Tuke Nd, in Edington 2013:11).

Ultimately, Tuke’s plan came to fruition and although many aspects of The Retreat’s service to patients declined in the years after the institution’s founding, its physical offerings were never one of them and the environment Tuke curated for the healing mind is still admired in the hills of York to this day (Edington 2013).

While there is significant controversy over the degree to which moral treatment affected positive change in practice, few would dispute that figures like Pinel and Tuke raised important questions about what asylums were and what they ought to be. If significant on nothing more than a symbolic level, for those it decreed as patients and not burdens, it represented a beacon of hope and light at the end of a centuries long tunnel of abuse and neglect. For lay people and stewards of medicine, it symbolized the need to do better for a criminally underserved awaken to how little sits between themselves and the madness they deemed worthy of inhumane treatment.

Amidst broader undercurrents of social change and the first major waves of advocacy for “problem populations” in the U.S (Digby 1983:223), Pinel’s ideas quickly garnered attention from administrators of existing asylums, emerging leaders in American psychiatry and medicine, and poised reformists alike. As the influence of moral treatment spread to the U.S. in the early 1800s, something attributed to have originated through letters exchanged between William Tuke’s Grandson, Samuel, and the American Quakers in Philadelphia, it began to shape how new institutions were being built and how old institutions were being reformed (Digby 1983; Edington 2013). While the former will be discussed in the next subsection under the Kirkbride Plan, the latter can be exemplified by the transition of New York Hospital’s Ward for the Curable Insane into Bloomingdale Asylum, a sprawling inpatient facility in Morningside Heights, New York.

After additional funding was acquired from private investors, many of which were friends of the nearby King’s College (now Columbia University), to bolster the mental health services in New York, the services provided by the old ward at New York Hospital were largely absorbed by Bloomingdale Asylum, an expansive private facility overlooking the Hudson River, officially opening its doors to patients in 1821. In an address to the public upon the opening of Bloomingdale Asylum in 1821, the hospital’s Governors emphasized their confidence in ‘moral treatment’ and stated it would be one of the institution’s guiding principles:

This institution has been established by the bounty of the Legislature of the state of New York, on the most liberal and enlarged plan, and with the express design to carry into effect that system of management of the insane, happily termed moral treatment, the superior efficacy of which has been demonstrated in several of the Hospitals of Europe ... This mild and humane mode of treatment, when contrasted with the harsh and cruel usage, and the severe and unnecessary restraint, which have formerly disgraced even the most celebrated lunatic asylums, may be considered as one of the noblest triumphs of pure and enlightened benevolence. (New York Asylum 1821: 9)

While moral treatment took on a variety of different forms as it gained popularity in mental institutions across the U.S. and Europe throughout the 19th century, the founders of

Bloomingtondale Asylum were especially loyal supporters of Pinel's original vision and its practice at The Retreat (New York Asylum 1821:5-12).

The governors at Bloomingtondale Asylum were not alone in their attempt to integrate the tenets of moral treatment on a larger scale and around the same time, both Eastern State Hospital and Pennsylvania Hospital made efforts to relocate or expand their facilities to accommodate the increasingly dense populations around them. Consistent with the style of their origins, the Quakers of Philadelphia¹⁰ acquired capital to renovate Pennsylvania Hospital through *An Appeal To The Citizens of Pennsylvania* (1854), whereas advocates for the relocation and expansion of Eastern State Hospital solicited Virginia's state officials to fund their vision of an improved and expanded facility in the suburbs of Williamsburg (Commonwealth of Virginia N.d.). Both were successful and while Eastern State Hospital retained its title, the expanded ward dedicated to treating mental illness in Pennsylvania Hospital became known as the Pennsylvania Hospital for Mental and Nervous Diseases, or Kirkbride's Hospital (Institute of the Pennsylvania Hospital Collections N.d).

Although Eastern State Hospital was somewhat of an anomaly in the early 1800s in that it was one of the only public asylums in the country, by the end of the 19th century, they represented the majority of inpatient mental health programs as early advocates of large scale institutionalization in the U.S. viewed a public network of asylums as preferable to a private system based on its superior accessibility to patients and capacity to implement means of standardization and accountability for physicians and asylum administrations (Michel 1994).

Institutionalization, Part 1: Expanding Asylums and the Genesis of a National Movement

¹⁰ With help from Dr. Thomas Kirkbride, then superintendent of Pennsylvania Hospital for Mental and Nervous Disorders and architect of said renovations (Yanni 2003).

While the work of Philippe Pinel and William Tuke is considered foundational to the proliferation of mental asylums in America, without the right messenger, it is unlikely their influence would have been enough to put the gears of the U.S institutionalization movement in motion. However, after being acquainted with lunacy reform during a visit to England in 1836, an American school teacher by the name of Dorothea Dix grew inspired to become that messenger and her stewardship of moral treatment is now regarded as some of the most effective advocacy work in American history (Parry 2006:624).

Throughout her trip, Dix had the good fortune of meeting a number of prominent figures in the effort to reform Victorian era asylums including William Tuke, during a visit to his newly founded asylum, The Retreat, in addition to Elizabeth Fry, a famous prison reformer, and William Rathbone, a politician from Liverpool (Michel 1994). Although Dix had no prior experience in medicine, lobbying, or politics, after a year in England she was not only equipped with the teachings of moral treatment, but also strategies to successfully deliver the message and advance her progressive agenda in front of U.S. legislators (Parry 2006). Discussing the formative role of Dix's trip to the U.K. in her 1994 paper, "Dorothea Dix; or the Voice of the Maniac," Sonya Michel explains:

Dix learned about moral treatment when, during an extended stay in England in 1836, she visited York Retreat, the mental hospital founded by Tuke. Her English host was the prominent Liverpool Reformer William Rathbone, and it was probably through him that Dix encountered testimony from the 1815 parliamentary hearings on lunacy reform. According to Gollaher, the memorials closely followed the narrative structure of the British texts. (Michel 1994:50)

Dix returned to the U.S. in 1837, at which time she decided to investigate the conditions of mental patients in America by visiting prisons, almshouses, and asylums across the country (Parry 2006).

While Dix had conversations with hundreds of psychiatrists and mental patients over the course of her career in mental health reform (1837-1861), few benefited her cause more than Dr.

Thomas Kirkbride. In addition to being a close friend of Dix's, Kirkbride was a lifelong Quaker and the superintendent of Pennsylvania's Hospital for Mental and Nervous Diseases for over 40 years (1840-1883) (Yanni 2003). Like Dix, Kirkbride was a disciple of moral treatment; however, while Dix furthered its teachings as lobbyist, Kirkbride focused on refining its practice and offering his findings to lay activists like Dix, as well as psychiatrists and asylum superintendents throughout the U.S. He especially took to the ideas on the importance of nature and architectural design to the successful treatment of mental patients. Yet, when he assumed the role of superintendent at Pennsylvania Hospital in 1840, Kirkbride found the asylum's grounds to be insufficient for providing the type of treatment that he envisioned was taking place at The Retreat (Yanni 2003).

With the goal of communicating desired renovations for his asylum, Kirkbride inadvertently made what would become the greatest catalyst of the U.S. institutionalization movement and Dorothea Dix's campaign thereof: an architectural blueprint of what he considered to be the best structure for asylums practicing moral treatment (Shorter 1997). Dubbed the "Kirkbride Plan" and published in his 1854 book, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*, Kirkbride's work included extensive instructions on everything from proper sewage removal to the manipulation of ventilation shafts in order to give patients more fresh air. While Kirkbride's architecture was aesthetically pleasing in practice, the true beauty of his plan lied in its detail; so long as a community had his book and the funding to source raw materials, little imaginative work was required to provide sanctuary for the mentally ill (Yanni 2003).

Armed with Dr. Kirkbride's blueprints and a surplus of charisma and wit, Dorothea Dix was able to convince Congress of allocating funds for state asylums. However, upon having her

bill vetoed by then president, Franklin Pierce, Dix decided to transition her campaign to state legislators (U.S. National Library of Medicine 2014). Writ large, state representatives heeded her concerns, even when it strained their own state budgets, and according to the U.S. National Library of Medicine, “by 1890, every state had built one or more publicly supported mental hospitals” (2017:1).

Developments in Psychiatry and Institutional Treatments in the 20th Century

At the halfway mark of the 20th century, America’s network of public asylums were responsible for far more patients than they had been designed to hold, with estimates topping over 500,000 patients in 1955 (U.S. National Library of Medicine 2017). While the immense burden of overcrowding often left doctors and nurses without time to treat patients, it also forced psychiatrists to adapt and create a series of new treatments for mental disorders; albeit, with varying degrees of success (Shorter 1997). This section will briefly address some of the most prominent treatments used in U.S. mental asylums, beginning with somatic treatments.

In Joel Braslow’s 2000 article “Lessons from the History of Somatic Treatments,” Braslow describes somatic treatments as a class of psychiatric treatments which focused on bodily interventions to cure the mind. While somatic treatments gained prominence in psychiatry during the 20th century, there were a number of somatic treatments in practice at asylums across the U.S. before this point. Of this group, hydrotherapy is one of the oldest and most widely used as it was co-opted by early supporters of moral treatment and general medical practitioners alike. Although many had lofty expectations for its ability to heal, there was, and still is, a degree of scientific merit to hydrotherapy regarding its ability to calm the nervous system and stimulate vascular blood flow (Braslow 2000:232).

While a number of different types of hydrotherapy have been practiced in psychiatry, Braslow cites the (continuous) bath and the wet sheet pack,” to be the most widely used; the former consisting of extended bathing periods in warm water, the latter of wrapping patients in sheets of either very warm or very cold water for brief periods of time, with especially cold sheets for the most agitated patients. In addition to its simplistic nature, hydrotherapy was also cost effective making it especially useful for public institutions with limited budgets. Nevertheless, according to Braslow: “the scientific luster of hydrotherapy faded over the following three or four decades, psychiatrists commonly prescribed it [hydrotherapy] until they gradually replaced it in the 1940s and 1950s first with ECT [electroconvulsive therapy] and later with antipsychotic drugs (Braslow 2000:233).

Similarly to hydrotherapy, ECT became a staple of treatment protocols in U.S. asylums for its cost-effectiveness and alleged scientific backing. ECT was created as a safer alternative to insulin shock therapy, which had been briefly popular in the early 1900s, under the auspice that inducing convulsions had potential to help patients suffering from disorders with psychotic features such as schizophrenia and manic depression. However, according to Braslow, there were more potential benefits to implementing ECT and furthermore it paired well with behavioral therapies. In his paper on somatic treatments Braslow remarks,

Of particular interest is that state hospital physicians, though commonly portrayed as employing ECT as a means of patient control, often used the treatment as a means of enhancing a patient's accessibility toward psychological interventions. State hospital doctors frequently recommended both psychotherapy and electroshock simultaneously on many of their patients, believing that the two modalities acted synergistically. (Braslow 2000:235)

While the varying methods of administering ECT produced a mix bag of results, it has been heavily researched and improved upon since its origin in the 1930s and is still administered in inpatient facilities today (Shorter 1997).

For more serious cases of mental illnesses, psychiatrists often turned to lobotomy in favor of somatic treatments like hydrotherapy or ECT. While psychosurgery did not originate in the U.S., it took little time to receive a full endorsement from American Medical Association (AMA) after American psychiatrists took interest in the research of two Portuguese doctors, Dr. Antonio Moniz and Dr. F. Lima (Shorter 1997). The pair extensively studied and advocated for the benefits of psychosurgery during the 1930s (Faria 2013). For Moniz and Lima, lobotomy reflected a crude, yet viable solution to the immense overcrowding in asylums throughout the U.S and Europe, and after experiencing modest success in a trial of frontotemporal lobotomies, they published their work in 1936 and caught the attention of neuroscientists and psychiatrists alike (Faria 2013).

Dr. Walter Freeman and Dr. James Watts are recognized as the first to formally perform psychosurgery in a research study evaluating its potential for use in American psychiatry. In their study, the duo completed 200 lobotomies with a mixed bag of patient outcomes; “63% improved; 23% had no improvement; and 14% were worsened or succumbed to their surgery” (Faria 2013). Although their results are quite morbid by today’s standards, they were encouraging at a time when asylum staff were running out of options. Nevertheless, for Watts, the 13% of their patients who either died or succumbed to further injury was enough to make him walk away from his line of work and he decided to sever his partnership with Freeman shortly after their report was published.

On the other hand, Freeman was enthralled by their findings and over the next 20 years, he conducted thousands of lobotomies on his own, rightfully earning his nickname as “the lobotomist” (Faria 2013). Ultimately, the psychiatric establishment sided more with Dr. Freeman than Dr. Watts, and it is estimated over 60,000 lobotomies were conducted between the U.S and

Europe between the years 1936 and 1956, the practice losing favor after FDA's approval of the drug Chlorpromazine in 1954 and the subsequent rise of psychopharmacology (Faria 2013).

The Rise of Psychopharmacology and Fall of the Asylum

In the *History of Psychopharmacology* (2019), Joel Braslow and Stephen Marder analyze how pharmaceutical drugs have changed the landscape of mental healthcare in the U.S. despite initial uncertainty. In their discussion the duo posits, “Physicians rarely claimed that drugs actually treated mental illness, rather they sedated, calmed, and soothed. Yet like physical restraint, according to most practitioners, they hardly counted as treatment” (Braslow and Marder 2019:1). While this may no longer be the case, their argument is apt in describing the first classes of drugs used to quiet patients including the first to hit U.S. markets, chlorpromazine (i.e., Thorazine).

In an article published by the *American Journal of Psychiatry* in 1954, it was stated that “Thorazine may be applied to the treatment of all conditions... such as anxiety states, severe neurosis—including obsessions—symptoms following drug withdrawal, manic-depressive disorders, certain cases of acute and florid schizophrenia, and in a wide variety of psychosomatic disorders (Wortis in Shorter 1997:508). While later research would show this claim to be rather lofty and exaggerated, the significance of Thorazine, and other early classes of drugs (e.g., sedatives, barbiturates, tranquilizers) transcended its therapeutic potential, as it opened the door for better pharmaceutical interventions and is attributed to have ushered in the “golden age” of psychopharmacology, in part, as it demonstrated the profitability of treating mental illness to the private sector (Braslow and Marder 2019). While more effective types of drugs such as

antipsychotics and antidepressants followed not long after the release of Thorazine, few were put into practice before most asylums were emptied or shut down (Shorter 1997).

CHAPTER 2: METHODS

This paper uses the 2018 Mental Health Client Level Data (MH-CLD)—provided by the Substance Abuse and Mental Health Services Administration (SAMHSA)—to perform a cross-sectional analysis of the individuals served by inpatient mental health facilities in the United States. The MH-CLD is composed of two data sets submitted annually by individual state mental health agencies (SMHAs), the Mental Health Client Level Data (MH-CLD), and the Mental Health Treatment Episode Data (MH-TEDS). Whereas the former uses medical records to report patients' demographic characteristics, the latter uses treatment episode records (i.e., treatment facility admissions and discharges) to report their mental health characteristics (e.g., cause for seeking treatment, treatment facility type, treatment outcome, etc.). Additionally, co-occurring substance abuse and mental health disorders are tracked through the MH-TEDS reporting system.

State mental health agencies began reporting client-level data annually in 2011. Since then, SMHAs have been responsible for providing accurate data on all treatment facilities under their jurisdiction once every 12-month annual reporting period (SAMHSA 2020:1-3). Each SMHA can use either the state fiscal year (July 1st-June 30th) or the calendar year (January 1st-December 31st) as their respective reporting period; however, nearly all in the 2018 MH-CLD use the state fiscal year. To ensure consistency, the Center for Behavioral Health Statistics (CBHSQ), a subsidiary of the Substance Abuse and Mental Health Services Administration, distributes up-to-date MH-CLD instruction manuals to SMHAs each year and oversees all procedures pertaining to data collection and reporting. After the 12-month reporting period and completion of data collection, the MH-CLD is made available to the public, and it is used by SAMHSA to inform five mental health National Outcome Measures, or NOMS:

1. Access to services
2. Stability in family and living conditions
3. Utilization of psychiatric inpatient beds
4. Retained employment (adults) and return to/stay in school (children)
5. Criminal justice involvement

While the MH-CLD is considered to be sufficient for assessing the aforementioned NOMs, given its inclusion of institutionalized populations and discrepancies between state procedures (e.g., licensing, certification, regulation of private v. public facilities, etc.), it is not considered a nationally representative sample of mental health. Nonetheless, for researchers interested in America's institutionalized population, the MH-CLD is one of, if not the single most, comprehensive source of data.

Unit of Observation, Sampling & Data Analysis

While the treatment episode would typically be the unit of analysis for the MH-TEDS when it is used in conjunction with the MH-CLD, as is done for the purposes of this paper, each treatment episode is matched with its respective client and their demographic profile in the MH-CLD, and the individual served becomes the unit of analysis. This is true for both the 2018 MH-CLD and this paper. With regards to coverage, the MH-CLD includes data on clients of all ages, mental health diagnoses, and treatment programs (e.g., community-based outpatient, telehealth conferencing, crisis services, etc.). Geographically, all U.S. states and territories are required to report MH-CLD data; however, if SAMHSA's standards for data collection are not met, or an insufficient number of cases are reported, a reporting entity can be excluded from the MH-CLD. The 2018 MH-CLD excludes Alaska, American Samoa, the Federated States of

Micronesia, Georgia, Guam, Kansas, Maine, Marshall Islands, New Hampshire, New Jersey, and the U.S. Virgin Islands (SAMHSA 2020).

Data from the 2018 MH-CLD was obtained through the Substance Abuse and Mental Health Data Archive (SAMHDA) and analyzed with IBM's Statistical Package for the Social Sciences (SPSS). Data analysis for this paper was performed in two parts; the first using a purposive sample of the MH-CLD's subpopulation of institutionalized patients, the second using the MH-CLD's entire adult population (indiscriminate of treatment setting) to compare variables as predictors of institutionalized status. Whereas the former was achieved with univariate frequency tables and cross-tabulations, the latter was performed with a binary logistic regression.

To separate the MH-CLD's subpopulation of institutionalized individuals, SPSS's *select cases* function was used with the following equation: $((AGE \geq 4 \ \& \ AGE \leq 14) \ \& \ (SPHSERVICE = 1 \ OR \ OPISERVICE = 1))$. Values 4-14 for the variable AGE reflected age groups containing individuals 18 years of age to 65 years and up. Variables SPHSERVICE and OPISERVICE reflected whether individuals had received care in a state mental hospital or private inpatient facility, respectively. In both SPHSERVICE and OPISERVICE, the value "1" indicated yes. When used, this filter narrowed valid cases from the 2018 MH-CLD's total population (N) of 6,213,791 to a sample (n) of 313,179.

For the regression analysis, SPSS's *select cases* function was again used, this time with the following filter: $(AGE \geq 4 \ \& \ AGE \leq 14)$. When applied, this filter produced 4,409,107 valid cases, reflecting the total population of adult clients covered by the 2018 MH-CLD (N_{adult}). The dependent variable in this model was INPATIENTPREDICT, which was recoded from SPHSERVICE and OPISERVICE with the following equation: $((SPHSERVICE = 1) \ OR$

(OPISERVICE = 1)). Responses for the dependent variable were coded into a binary value set, with “1” representing individuals who received treatment in an inpatient facility and “0” representing individuals who did not receive treatment in an inpatient facility.

Additional Recoded Variables

In addition to INPATIENTPREDICT, variables AGE, MH1, MH2, and MH3 were all recoded for univariate and bivariate analyses. AGE was recoded into AGE2 for both simplicity and to accommodate the exclusion of non-adults. While there were 14 age groups ranging from 0-11 years old to 65 years and older in the original variable AGE, the new variable, AGE2, was created by condensing the values which contained adult cases (4-14) into three groups: 18-44 years old; 45-64 years old and 65 years and older. The recoded age groups were selected to match those used by the U.S. Census, which labels them as “the younger working-age population,” “the older working-age population,” and the “65 and over population,” respectively (Howden and Meyer 2011:2).

In the 2018 MH-CLD, data on clients’ mental health diagnoses is captured through three variables: MH1, MH2, and MH3. While collecting data this way allows SMHAs to record up to three diagnoses per patient, it makes the comparison of diagnosis rates more challenging. Although flag variables for each mental disorder diagnosis were created for the 2018 MH-CLD (i.e., a single, separate variable indicating the frequency of a diagnosis across MH1, MH2, and MH3) each reflects only the frequency of its respective disorder. Thus, comparing each diagnosis’s composite frequency would entail comparing each of the 13 flag variables. To streamline this, the variable MHFREQ was created using SPSS’s multiple response set feature and custom table settings. Specifically, the value set shared by MH1, MH2, and MH3

representing each diagnosis type was aligned in rows, and the total frequency of each diagnosis across the three original variables was then totaled into the corresponding column. This allows for the comparison of total diagnoses frequency in a single variable as opposed to 13.

CHAPTER 3: RESULTS & DISCUSSION

While there remains considerable debate over the legitimacy and function of mental institutions in American history, supporters of both Erving Goffman's total institution model and American psychiatry's traditional-medical model continue to wield their view of the past in debates about the present and future. While Goffman's work has been habitually revisited by disciples and critics alike since the publication of *Asylums* in 1961, few have done so in the last decade and even fewer have done so using empirical data. This paper contributes to existing literature by providing a contemporary analysis of America's mental institutions, identifying which, if any, historical perspectives still hold merit, and providing evidence-based suggestions on the most pressing policy debates concerning inpatient mental health care. In this chapter, quantitative results from the 2018 MH-CLD are summarized and interpreted first, followed by a discussion of this paper's findings in relation to current debates of public policy and existing literature.

Quantitative Results

Of the 2018 MH-CLD's 40 variables, nearly all can be classified as indicators of either demographic or mental health characteristics. Using variables from both of these categories, this paper sought to answer the fundamental question: who is in America's mental institutions, and why? Beginning with measures of demographic characteristics, this section will cover the univariate and bivariate analyses performed on the 2018 MH-CLD's subpopulation of institutionalized individuals ($n=313,179$), followed by the binary logistic regression assessing predictors of institutionalized status among the total population of adults in the 2018 MH-CLD ($N^{\text{adult}}=4,409,107$). For comparisons to the general population, estimates of U.S. population

demographics were sourced from the American Community Survey (ACS) 2018 5-year Data Profiles and is used to provide context throughout the subsequent analyses. For comparisons to a nationally representative sample of mental health data, the 2018 National Survey of Drug Use and Health is likewise used to provide context.

Univariate Analysis

As noted in Table 1, of the 313,179 adults served by inpatient mental health facilities, 183,565 (58.6%) were reported as male and 129,504 (41.4%) were reported as female, with 110 (0.03%) missing cases. Compared with the distribution of sex in the 2018 ACS—which was reported as 49.2% male and 50.8% female—Table 1 would suggest males are slightly overrepresented in America’s institutionalized population; however, this is largely consistent with historical trends and literature on gender differences in the presentation of mental illness.

Table 1

Sex

	N	%
Male	183,565	58.6%
Female	129,504	41.4%
Missing/invalid	110	0.0%
Total	313,069	100.0%

In studies such as Rosenfield, Phillips & White’s “Gender, Race, and the Self” (2006) mental illnesses have been shown to present primarily through externalizing behaviors for men and internalizing behaviors for women. While this does not speak to the root causes of mental illness, with regards to America’s institutionalized population, the unequal gender distribution may be partially explained by the increased tendency of males to present their psychological

problems outwardly, resulting in more engagements with the criminal justice system, civil commitment proceedings, or other external pressures to seek inpatient care. Moreover, historical studies of gender differences in U.S. mental hospital admissions such as Stroup and Manderscheid (1988) show that males have consistently received inpatient mental health treatment at slightly higher rates than females, with spikes after periods of major armed conflicts involving the U.S. such as WW1, WW2, and the Vietnam War.

Whereas data from the 2018 MH-CLD on gender was consistent with historical trends, a univariate analysis of age (AGE2) tells a different story. In contrast to the significant representation of senior patients in U.S. asylums from the late 1800s through the 1940s—which is estimated to have fluctuated between 13%-31% of the total institutionalized populations (Grob 1977:37)—individuals 65 years and older comprised just 5.1% of those served by inpatient facilities in 2018. The remaining 94.9% of institutionalized adults consisted of 64% within the 18-44 years old age group and 30.9% within the 45-64 years old age group. While this does not lend credence to the question of who *is* in America's mental institutions, it speaks to the equally important question of who *is not* in America's mental institutions. Unlike the early 20th century, when the overrepresentation of seniors—many of which suffered from little more than old age, and simply had nowhere else to go—suggested that providing custody to the elderly was a key function of American asylums (Grob 1977), the underrepresentation of seniors in the 21st century suggests this is no longer the case. If nothing else, it implies there is at least one less competing interest with the intended function of mental institutions today than there was in the past.

Table 2

<i>Age (Recoded)</i>	N	%
18-44 years	200,359	64.0%
45-64 years	96,874	30.9%
65 years and older	15,946	5.1%
Total	313,179	100.0%

Racially, the largest portion of the sample was White (63.5%), followed by the 21% reported as being Black or African American. Conversely, the least observed racial group in the sample was Native Hawaiian or Other Pacific Islander with 0.3%, followed by Asians (1.5%), American Indian/Alaska Native (2.0%), and a combined group of individuals with some other race alone or two or more races (5.8%). Compared to the general population in 2018 ACS, Asian Americans were underrepresented with a 1.5% share of the sample as opposed to the race's 6.5% share of the general population. Conversely, at 21.0%, of Black or African American individuals constituted a 7.0% larger share in the sample than was observed in the general population the same year (U.S. Census Bureau 2019). While differences in the racial distribution of the sample and the general population can be gleaned from the univariate frequencies in Table 3, the discussion of their significance was supplanted to the treatment of race in the following section on bivariate analysis. This allows for a more thoughtful consideration of racial demographics alongside indicators of mental health characteristics and literature that is relevant, but not confined to, race.

Table 3

<i>Race</i>	N	%
American Indian/Alaska Native	6,250	2.0%
Asian	4,774	1.5%
Black or African American	65,847	21.0%
Native Hawaiian or Other Pacific Islander	786	0.3%
White	199,005	63.5%
Some other race alone/two or more races	18,296	5.8%
Missing/invalid	18,221	5.8%
Total	313,179	100.0%

Geographic data in the 2018 MH-CLD was categorized by the U.S. Census regions and reported under variable REGION. Of the 313,179 individuals served, the majority were from the South and the West, with 31.8% and 31.9% reported, respectively. Of those remaining, 19.9% belonged to the Midwest, 16.2% to the Northeast, and 0.2% to Other Jurisdictions. The only notable differences between the geographic distribution of the sample and the distribution of America's general population was a slightly larger portion of cases from the West (31.9% of n v. 23.8% of general pop.) and a slightly smaller portion of cases from the South (31.8% of n v. 38.1% of general pop.). The proportion of individuals served in the sample from the Northeast and the Midwest were both within a single percentage point of the national distribution (U.S. Census Bureau 2019).

Table 4

<i>Census Region</i>	N	%
Other jurisdictions	573	0.2%
Northeast	50,735	16.2%
Midwest	62,449	19.9%
South	99,535	31.8%
West	99,887	31.9%
Total	313,179	100.0%

While no cases were reported as missing for variable REGION, results should be interpreted with caution due to the presence of geographic exclusions. As mentioned in Chapter 3, the 2018 MH-CLD did *not* include data from the following states and territories due to errors in SMHA reporting or insufficient data: Alaska, American Samoa, the Federated States of Micronesia, Georgia, Guam, Kansas, Maine, Marshall Islands, New Hampshire, New Jersey, and the U.S. Virgin Islands (SAMHSA 2020). The absence of Georgia and New Jersey is especially worthy of consideration given their respective statuses as the 9th and 11th most populated U.S. state or territory in 2018 (U.S. Census Bureau 2019).

Shifting to indicators of mental health characteristics, variables SMI and NUMMHS were used to measure the prevalence of severe mental illness/severe emotional disturbance and multiple mental health diagnoses within the sample population. According to SAMSHA's "Mental Health Annual Report 2013-2018," serious mental illness is defined as, "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities" (2020B: Appendix D). As is expressed in row 2, column 2 of Table 5, 80% of individuals served by inpatient mental institutions had a severe mental illness (SMI). While SMI will be the subject of further discussion further in bivariate and multivariate analysis models, it should be noted that, at 80%, it was the single most prevalent characteristic in the sample population. With regards to the distribution of variable NUMMHS, Table 6 shows that a sizable portion of the sample (38.4%) had more than one mental health diagnosis. When the total number of diagnoses are summed and divided amongst the sample, the average calculates out to 1.44 mental health diagnoses per patient.

Table 5

SMI Status

	Frequency	Percent
SMI	250456	80.0%
Not SMI	49721	15.9%
Missing/invalid	13002	4.2%
Total	313,179	100.0%

Table 6*Number of mental health diagnoses reported*

	Frequency	Percent
0	27,668	8.8%
1	165,189	52.7%
2	74,460	23.8%
3	45,862	14.6%
Total	313,179	100.0%

Variable MHFREQ was used to model the distribution of mental disorder diagnoses within the institutionalized population. As reflected by the sum of column 1 in Table 7, there were a total of 437,659 mental disorder diagnoses observed between the 313,179 individuals served. Of the 437,659, schizophrenia and other psychotic disorders was the most prevalent diagnosis with 111,434 cases, representing over a quarter of all diagnoses (25.5%) and affecting 35.6% of the sample population. Depressive disorders accounted for the second most cases with 91,213, reflecting 20.8% of all diagnoses and prevalence in 29.1% of individuals served. Bipolar disorder and anxiety disorders were the only other diagnoses with a double-digit portion of the 437,659, with 13.9% and 10.4% shares respectively, equating to 19.3% and 14.5% prevalence in the sample respectively.

Table 7

Total Diagnosis Frequencies (MHFREQ)

	Count	Table %
Trauma- and stressor-related disorders	33,567	7.7%
Anxiety disorders	45,508	10.4%
Attention deficit/hyperactivity disorder (ADD/ADHD)	6,900	1.6%
Conduct disorders	1,424	0.3%
Delirium, dementia	3,461	0.7%
Bipolar disorders	60,587	13.8%
Depressive disorders	91,213	20.8%
Oppositional defiant disorders	609	0.1%
Pervasive developmental disorders	1,262	0.3%
Personality disorders	21,562	4.9%
Schizophrenia or other psychotic disorders	111,434	25.5%
Alcohol/substance use disorders	26,737	6.1%
Other disorders/conditions	33,395	7.6%
Total	437,659	100.0%

Note. Total distribution of disorders across primary, secondary, and tertiary diagnoses of n.

^aTotals calculated with missing/invalid cases excluded.

^bPercentages may not equal 100% due to rounding.

Bivariate Analysis

The first independent variable considered in bivariate models was RACE. Among critics of American psychiatry, the fear of racial bias affecting access and patient experiences in institutionalized care settings is widespread, and for good reason. As discussed in Jonathan Metzl's "Guns, Race, and the History of Schizophrenic Violence" (2016), the association between dangerousness and mental illness in the U.S. largely grew out of discriminatory practices during the civil rights movement. Specifically, Metzl refers to the popular sentiment among psychiatrists in the 1960s that Black, male protestors were not merely upset with racial injustices and protesting this much, rather, they were manic, hostile, and likely affected by the "protest psychosis," or as it was labeled in the *DSM-II*: schizophrenia (Metzl 2016:211).

As it pertains to contemporary structures of inpatient care, researchers such as Metzl (2016) and Grob (1977) have raised concerns that continued discrimination against Black

Americans in psychiatric diagnosis and civil commitment proceedings could display as either their significant overrepresentation or underrepresentation in institutionalized settings. Whereas the former would suggest the type of social control described by Goffman, Foucault, and Szasz, the latter would lend credence to concerns over access and inequality in the U.S. healthcare (NAMI 2020; MHA 2020). Disproportionate racial demographics can likewise be considered through the distribution of mental health characteristics. This much was demonstrated by Snowden, Hastings, and Alvidrez's 2009 study "Overrepresentation of Black Americans in Psychiatric Inpatient Care" in which they posited:

The presence of a diagnosed psychiatric disorder is an important indicator of treatment need. Black Americans, paradoxically, show lower rates than white Americans of diagnosable lifetime disorders, but disorders among blacks can be especially severe and persistent. In addition, the prevalence of schizophrenia is higher among blacks than among whites. Thus it is possible that the greater inpatient representation of blacks may be the result of differences in clinical factors (2009:799-780).

In the summary of cross-tabulations below, difference in racial representation is considered both as an indicator of social control—and thus the total institution model—and as an indicator of treatment need—modeled in Snowden et al. (2019) and suggestive of the traditional medical model.

Beginning with the cross tabulation of age (AGE2) and race (RACE), data from Table 8 present few notable differences in the distribution of age groups across races. Moreover, there were no outliers and when compared to row margins, all cells fell within 10.7% of the average distribution. Between the three age groups—18-44 years old, 45-64 years old, and 65 years and older—63.7% belonged to the youngest group. As mentioned in the univariate analyses, this reflects a significant departure from the periods in which mental institutions were overwhelmed with elderly patients and hosted few younger adults. Regarding measures of significance and association, Chi Square testing returned a significant value at $P < 0.05$, however, the measures of

association–Lambda and Goodman and Kruskal tau–showed the relationship to be negligible with a Lambda value of .000 and Goodman and Kruskal tau of .004.

Table 8

Age Recoded x Race

			Race						
			American Indian/Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	Some other race alone/two or more races	Total
Age Recoded	18-44 years	Count	4300	3190	43380	547	122794	13609	187820
		% within Race	68.8%	66.8%	65.9%	69.6%	61.7%	74.4%	63.7%
	45-64 years	Count	1701	1314	19973	217	64783	4208	92196
		% within Race	27.2%	27.5%	30.3%	27.6%	32.6%	23.0%	31.3%
	65 years and older	Count	249	270	2494	22	11428	479	14942
		% within Race	4.0%	5.7%	3.8%	2.8%	5.7%	2.6%	5.1%
Total	Count	6250	4774	65847	786	199005	18296	294958	
	% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

^aPost hoc testing for directional measures and values: Lambda (λ): .000; Goodman and Kruskal tau (τ): .004.

^b18,221 missing cases (5.8%) were excluded from the sample's original total of 313,179.

To examine the geographical distribution of the sample by race, variables REGION and RACE were cross tabulated, the results of which are displayed in Table 9. In contrast to the cross tabulation of race and age, there were noteworthy differences in the racial geographical of n. Whereas Black individuals were most concentrated in the South with 45.7% of the sample's total Black population, the largest portion (47.8%) of Asian individuals were from the West. Unsurprisingly, the majority of Native Hawaiians (67.8%) and American Indian/Alaska Natives (52.3%) were also from the West.

Table 9

Census Region x Race

			Race						
			American Indian/Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	Some other race alone/two or more races	Total
Census region	Other jurisdictions	Count	11	13	4	2	80	380	490
		% within Race	0.2%	0.3%	0.0%	0.3%	0.0%	2.1%	0.2%
	Northeast	Count	136	606	14573	35	29975	4319	49644
		% within Race	2.2%	12.7%	22.1%	4.5%	15.1%	23.6%	16.8%
	Midwest	Count	1834	896	9329	90	42388	2322	56859
		% within Race	29.3%	18.8%	14.2%	11.5%	21.3%	12.7%	19.3%
	South	Count	999	975	30121	126	61721	3357	97299
		% within Race	16.0%	20.4%	45.7%	16.0%	31.0%	18.3%	33.0%
	West	Count	3270	2284	11820	533	64841	7918	90666
		% within Race	52.3%	47.8%	18.0%	67.8%	32.6%	43.3%	30.7%
	Total	Count	6250	4774	65847	786	199005	18296	294958
		% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

^a18,221 missing cases (5.8%) were excluded from the sample's original total of 313,179.

^bPost hoc testing for directional measures and values: Lambda (λ): .003; Goodman and Kruskal tau (τ): .024.

To ascertain whether or not there were racial differences in key mental health characteristics, RACE was cross tabulated with the variables SMI, NUMMHS, and SCHIZOFLG, the first of which was SMI.

SMI reflects a binary flag variable indicating whether or not a client has a serious mental illness. As suggested by data displayed in Table 10, there were moderate differences between the prevalence of SMI across race, however, all were quite high. As mentioned previously, 80% of the sample was reported as having a serious mental illness. The highest prevalence of SMI was observed among Asians with 90.3%. The lowest was American Indian/Alaska Native at 75.8%. SMI was observed at higher rates among Black individuals than it was in white people with percentages of 87.6% and 81.4% respectively. While this inherently reflects inequality, with regard to the concern raised in Snowden et al. (2009) on the overrepresentation of Black individuals without a need for treatment—evidenced by a lack of diagnosis—the 87.6% SMI prevalence suggest this to no longer be the case, thus reflecting a narrowing of inequality.

Table 10*SMI Status x Race*

			Race						
			American Indian/Alaska Native	Asian	Black or African American	Native Hawaiian/ Pacific Islander	White	Some other race alone/two or more races	Total
SMI status	SMI	Count	4571	4081	55267	668	156166	14592	235345
		% within Race	75.8%	90.3%	87.6%	88.5%	81.4%	84.2%	83.0%
	Not SMI	Count	1459	438	7822	87	35581	2737	48124
		% within Race	24.2%	9.7%	12.4%	11.5%	18.6%	15.8%	17.0%
Total		Count	6030	4519	63089	755	191747	17329	283469
		% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

^aThe percentage of SMI did differ significantly by race, $\chi^2(5, N = 283469) = 0.00, p = .05$.

^bPost hoc testing for directional measures and values: Lambda (λ): .000; Goodman and Kruskal tau (τ): .006.

^c29,710 missing cases (9.5%) were excluded from the sample's original total of 313,179.

Race was also cross tabulated with the variable NUMMHS, the MH-CLD's indicator of how many mental health diagnoses were observed per client, the results of which are displayed in Table 11, Testing between the two variables yielded no substantive differences in the presence of multiple diagnoses between racial categories, with all cell values remaining within 10% of their respective marginal averages.

Table 11*Number of Mental Health Diagnoses x Race*

			Race						
			American Indian/Alaska Native		Black or African American	Native Hawaiian or Other Pacific Islander	White	Some other race alone/two or more races	Total
Number of mental health diagnoses reported	0	Count	555	323	5548	58	17465	1912	25861
		% within Race	8.9%	6.8%	8.4%	7.4%	8.8%	10.5%	8.8%
	1	Count	3027	2990	40224	374	99523	10689	156827
		% within Race	48.4%	62.6%	61.1%	47.6%	50.0%	58.4%	53.2%
	2	Count	1429	926	13374	189	50249	3604	69771
		% within Race	22.9%	19.4%	20.3%	24.0%	25.3%	19.7%	23.7%
	3	Count	1239	535	6701	165	31768	2091	42499
		% within Race	19.8%	11.2%	10.2%	21.0%	16.0%	11.4%	14.4%
Total	Count	6250	4774	65847	786	199005	18296	294958	
	% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

^aPost hoc testing for directional measures and values: Lambda (λ): .000; Goodman and Kruskal tau (τ): .006.

^b18,221 missing cases (5.8%) were excluded from the sample's original total of 313,179.

The last mental health variable cross tabulated with race was the flag variable for schizophrenia, SCHIZOFLG. Consistent with the findings of Snowden et al. (2009), schizophrenia was more prevalent among Black individuals than white individuals in the sample. Chi Square testing showed significance at $P < 0.05$ and although measures of Lambda and Kruskal tau returned relatively weak associations with values of .015 and .038, respectively, the difference between Blacks and whites was substantive. Whereas 29.5% of whites in the sample were reported as having schizophrenia, 51% of Blacks were diagnosed with the disorder. Importantly, this highlights yet another way Blacks are overrepresented in inpatient facilities beyond their outsized share of the sample.

Table 12

*Schizophrenia or other psychotic disorder reported * Race Crosstabulation*

			Race						Total
			American Indian/Alaska Native		Black or African American		Native Hawaiian /Other Pacific Islander		
			Native	Asian	American	Islander	White		
							alone/two or	more races	
Schizophrenia or other psychotic disorder reported	No	Count	4605	2231	32288	409	140301	10818	190652
		% within Race	73.7%	46.7%	49.0%	52.0%	70.5%	59.1%	64.6%
	Yes	Count	1645	2543	33559	377	58704	7478	104306
		% within Race	26.3%	53.3%	51.0%	48.0%	29.5%	40.9%	35.4%
Total			Count	6250	4774	65847	786	199005	294958
			% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

^aPost hoc testing for directional measures and values: Lambda (λ): .015; Goodman and Kruskal tau (τ): .038.

^b18,221 missing cases (5.8%) were excluded from the sample's original total of 313,179.

Looking at cross tabulations of race and sex, Figure 1 displays the relatively even male:female ratios observed across racial categories, all of which had males in the majority. The range between each race's percentage male was 10.6% with Black or African American having the highest percentage at 64.7%, and American Indian/Alaska Natives having the lowest at 54.4%. Of the individuals served who were white, 56.0% were male, placing the group at the second

lowest total percentage of males. While the difference in percentage male between White and Black or African American could be interpreted to suggest that Black men are being driven into institutional care at higher rates than their White counterparts for any number of reasons (e.g., increased referrals through criminal justice system, higher rates of mental illness due to social determinants of health, etc.), Black women are being denied access to institutional care more often than white women, or some combination of both, tests of association caution otherwise.

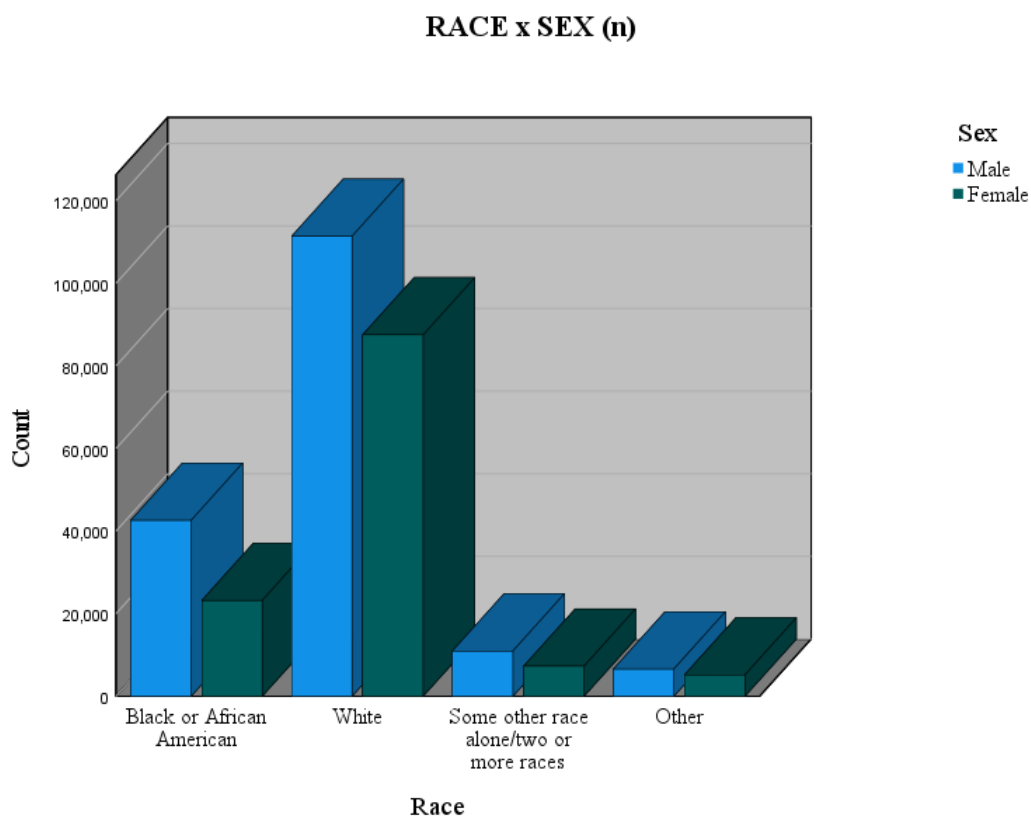
Table 13*SEX x RACE*

		Race						Total
		American Indian/Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	Some other race alone/two or more races	
Male	Count	3401	2766	42617	440	111402	10986	171612
	% within Race	54.4%	58.0%	64.7%	56.0%	56.0%	60.1%	58.2%
Female	Count	2848	2004	23223	346	87565	7303	123289
	% within Race	45.6%	42.0%	35.3%	44.0%	44.0%	39.9%	41.8%
Total	Count	6249	4770	65840	786	198967	18289	294901
	% within Race	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

^a18,278 missing cases (5.83%) were excluded from the sample's original total of 313,179.

^bPost hoc testing for directional measures and values: Lambda (λ): .000; Goodman and Kruskal tau (τ): .005.

Chi Square testing showed racial differences in gender frequencies to be significant at $P < 0.05$; however, with a Lambda value of .000 and a Goodman and Kruskal tau value of .005, it is more likely this was a product of the differences between column proportions rather than row values. Regardless of a weak proportional association, however, the imbalanced columns in Table 13 underscore the considerable differences between the raw frequencies of each racial category. Figure 1 displays the data from Table 8 in a 3-D bar chart to provide a visual representation of these differences.

Figure 1*3-D Bar Chart of RACE x SEX*

With 199,005 cases, White individuals composed 36.5% more of the sample than all other racial categories combined. Notably, this means that racial minorities comprised less than half of the sample population. On the other hand, it indicates that whites were underrepresented compared to their 72.7% share of the general population. This raises important questions of both accessibility and the notion that one of the primary functions of American psychiatry is to wield psychiatric diagnosis and inpatient treatment as instruments of social control (Goffman 1961; Foucault 1961; Szasz 1961). It appears that the gap between whites and non-whites described by studies such as Snowden et al. 2019 are closing broadly, however, there are still more blacks and less whites than the general population would lead you to expect.

In addition to RACE, GENDER was a variable of interest in bivariate analysis. While few substantive differences were found between sex and the MH-CLD's demographic variables, there were some noteworthy differences in variables of mental health including rates of anxiety, depression, and substance abuse problems. Table 13 reports anxiety disorder (ANXIETYFLG) observed among female inpatient clients at nearly double the rate of men with 19.5% and 11.0%, respectively. Tests of chi square (χ^2) and lambda (λ) showed the relationship to be significant at $P < 0.05$ with a small, but measurable association. This much was true for depressive disorder (DEPRESSFLG) as well, with diagnosis rates of 34.6% and 25.3% in males and females showing a significant, yet small relationship. Cross tabulations between GENDER and SAP (substance abuse problem) suggest the opposite with SAPs present in 53.1% of men and 41.4% of females.

While gender has not been historically central to the study of America's mental institutions, writ large, the same could have been said of race 50 years ago and of mental illness itself 100 years ago. Moreover, it has never been distal to the subject with sex being one of, if not the single most, researched variables in studies of the brain and behavior. Thus, as mental institutions appear to be shifting away from facilities of sedation and seclusion in favor of a more medicalized and specialized style of care, mental health characteristics should gain traction in academic and clinical spheres of research. As such, it retains importance to the findings of this paper and its recommendations for research and public policy.

Table 13

Anxiety Disorder x Sex

			Anxiety disorder reported		Total
			0	1	
Sex	Male	Count	163346	20219	183565
		% within Sex	89.0%	11.0%	100.0%
	Female	Count	104219	25285	129504
		% within Sex	80.5%	19.5%	100.0%
Total		Count	267565	45504	313069
		% within Sex	85.5%	14.5%	100.0%

^a110 missing cases (0.0%) were excluded from the sample's original total of 313,179.

^bPost hoc testing for directional measures and values: Lambda (λ): .039 Goodman and Kruskal tau (τ): .014.

Multivariate Analyses

*(See Appendix 3.a.-3.b.) Regression analysis excluded due to multicollinearity between variables of interest.

CHAPTER 4: CONCLUSIONS

In 2021, federal and state government officials have found themselves at an inflection point. With the country's existing mental health crisis exacerbated by a global pandemic, the demand for inpatient mental health care has never been higher; yet, its supply has never been lower (McKinsey & Co. 2020). Fundamentally, the issue is one of resource allocation and legislators must decide whether to: a) reinvest in inpatient care with trust that they are and will continue to be, different than they once were; or b) divest the remaining government funding from inpatient care, invest in community-based programming, and leave inpatient care to the private sector. To conclude this paper, the aforementioned will be considered in light of the quantitative results and literature discussed in this paper thus far. After which, policy recommendations will be offered along with directions for future research.

The Problem

To begin, it is worth refining the problem because there are many. Writ large, the demand for mental health services in the United States exceeds its supply. According to the National Council for Behavioral Health, while nearly 60% of Americans report seeking or desiring mental health care for themselves and/or their families in 2018, there was not enough to go around as evidenced by average appointment wait times of over a week, rising costs of treatment due to the commodification and rarity of mental health services, and the national shortage of inpatient beds (NCBH 2021). While these issues are inextricably intertwined, this paper seeks only to weigh in on the latter, that is, legislation and policy concerning the unmet demand for inpatient beds.

Turning to the numbers it is important to establish how supply and demand for inpatient beds are quantified. Typically, statistical analyses on the matter measure the number of beds per

100,000 in the population. In a 2008 study by Dr. E. Fuller Torrey and researchers at the Treatment Advocacy Center (TAC), the safe number of public inpatient psychiatric beds in America was estimated to be 50 per 100,000 citizens (Torrey, Entsminger, Geller, Stanley & Jaffe 2012). In 2013, a study conducted by the Organization for Economic Cooperation and Development, an international coalition of 34 countries including the U.S., estimated the number to be 68, however, 50 has largely remained the benchmark for assessing the availability of inpatient beds (OECD 2013).

In 2016, the last year for which psychiatric bed capacity has been tabulated per capita at the federal level, researchers from TAC reported the U.S. as having 11.7 state-psychiatric beds per 100,000 citizens (TAC 2016:1). This reflects a 96.4% decrease from 1955 when the national average reached 340 at the peak of institutionalization (Torrey, Entsminger, Geller, Stanley & Jaffe 2012). In the same report (“Going, Going Gone” 2016), TAC researchers cited the decline of state-psychiatric beds in America to have retained its linearity, meaning the 340 beds available in 1955 reflected the most in American history, whereas the 11.7 in 2016 reflected the least (TAC 2016:6).

While private facilities by no means make up the gap between the number of inpatient beds needed and those available, they do serve to increase the total inpatient psychiatric beds per capita—for those who can afford them. In the 2016 report “Trends in Psychiatric Inpatient Capacity,” researchers from the National Association of State Mental Health Program Directors (NASMHPD) used data from SAMHSA’s National Mental Health Services Survey (N-MHSS) to calculate inpatient psychiatric bed availability across all types of inpatient facilities (e.g., public, private, residential, etc.). Although public facilities are the only facilities that are accessible by

the entirety of the general population, when other facilities are added, the total number of inpatient psychiatric beds per 100,000 was reported to be 29.7% (NASMHPD 2016).

Regardless of the boost given when non-public facilities are added, there remains a considerable shortage of inpatient psychiatric beds for those who need them. While supply and demand have been discussed thus far, what lies at the heart of the problem, however, is what happens when those who need inpatient care never receive it. Among the most frequent outcomes for individuals with serious mental illnesses who do not receive treatment are transinstitutionalization to the criminal justice system, homelessness, and unemployment.

Importantly, this can be surmised without laying claim to the quality of care in inpatient mental health facilities, as studies such as Raphael and Stoll (2013) show there are consequences solely from the absence of a bed and a mentally ill individual's time spent elsewhere. Stating the results of their study "Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate" Steven Raphael and Michael Stoll stated:

It is certainly the case that a relatively high proportion of the currently incarcerated mentally ill would not have been incarcerated in years past and would likely be receiving inpatient treatment in a mental health facility. For the year 2000, our estimates indicate that there are 40,000-72,000 incarcerated individuals who in years past would likely have been hospital inpatients (Raphael and Stoll 2013:219).

The contribution of unmet inpatient psychiatric bed demand is likewise clear to unemployment in America. In the 2019 Annual Homeless Assessment Report (AHAR) submitted to Congress by the U.S. Department of Housing and Urban Development, 116,179 of the country's homeless population was reported as having a serious mental illness; however, some estimates place this figure as high as 140,000.

The final aspect of the inpatient psychiatric bed shortage problem which must be considered is its reverse causality. While the research shows mental illness as a clear impetus of

incarceration, homelessness, and unemployment, the same is true of incarceration, homelessness, and unemployment for mental illness, and the result is cyclical (Link and Phelan 1995). As more individuals demand for inpatient care is left unmet, more individuals become incarcerated, homeless, and unemployed; as more individuals become incarcerated, homeless, and unemployed, more individuals become mentally ill, and so on and so forth. One important caveat, however, is that the consequences of inpatient bed shortage on the social condition are not metered evenly, rather they are amplified among the most disadvantaged.

A 2012 study on the relationship between unemployment, race, and mental health by Arthur Goldsmith and Timothy Diette serves as just one example of this. While there is a body of research linking poor mental health to joblessness, Goldsmith and Diette sought to evaluate the effects of unemployment on mental health. Beyond finding evidence of long-term unemployment harming mental health, the study found the negative effects of joblessness to have the largest negative effects among Blacks and Latinos. In addition to offering strong evidence of reverse causality between employment and mental health, Goldsmith and Diette ultimately posit that the cost of mental health care should also be considered in terms of all that it saves, namely, the longevity of our mental health, the longevity of our participation in the workforce, and the maximal delay of our entry into the cycle of joblessness and poor mental health.

The Players

Just as the contemporary problems surrounding America's mental institutions are inseparable from the 60 years of political clashes that have taken place since the onset of deinstitutionalization, the key players on both sides are products of precedent and their positions have only calcified over the years. In reference to the policy issues surrounding asylums in the

20th century, opponents and proponents of institutional psychiatry have been referred to as the “total institution” camp and “traditional medical” camp, respectively; and although the continued applicability of these classifications could be justified on ideological grounds, by and large, this is not needed.

Several of the advocacy groups leading each camp in 2021 are the same which engaged in the policy debates of the 1960s and have retained faith in their founders’ vision of institutional care dearly. Within the total institution camp, Mental Health America (MHA) is a prime example. MHA was founded by Clifford Beers in 1950 after he endured horrific abuses at three separate Connecticut asylums between 1900-1903 (Parry 2010). Beers started the initiative with the mission of promoting community-based care, and 72 years later MHA is still on the case. Conversely, on the traditional medical side, the American Psychiatric Association (APA) that was founded in 1892 and pushed back against full-scale deinstitutionalization in the 1960s is the same APA seeking to capitalize on the COVID-19 pandemic’s ripple effect on mental health awareness in 2021.

Whereas the APA has as much stake in the revitalization of inpatient facilities as anyone, as a trade profession, they are outliers among the most vocal in current policy debates. The majority—on both sides—are of the MHA mold: large, multi-level non-profit organizations seeking influence in mental health politics at the state and federal level along with recognition as advocates for the greater good. Other than MHA, the National Alliance for Mental Illness (NAMI) retains the foremost influence in the modern total institution camp. This is likewise true for the Treatment Advocacy Center and Mental Illness Policy Org in the traditional medical camp.

Positions and Proxy Issues

While each side can be characterized by their differences, it is important to touch on their similarities. In regard to the mental health crisis generally, both concurrently acknowledge the demand for mental health services supersede the supply (MHA 2020; Mental Illness Policy Org 2020; APA 2020). Moreover, both acknowledge the harm of criminalizing mental illness and the importance of enriching resources for improved community mental health. While groups such as MHA and NAMI state their support for inpatient care for when there is no other option—and thus this could be considered a point of common ground—as is discussed later in this section, they have also more than once aligned themselves with groups who seek to shutter state mental hospitals, and if there is no accessible inpatient care, the “certain” situations in which they approve of it are little more than hypotheticals (Mental Health Policy Org 2020).

It is worth noting, however, that consensus has been reached between the two sides on select policy debates surrounding mental health care. One of the most prominent examples being the Helping Families in Mental Health Crisis Act of 2016. Among other things, the bill extended the Protecting Medicare Act of 2014, imposed more stringent accountability standards for SAMHSA, and mandated increased federal support for community-based SMI treatment (U.S. Congress 2016). Beyond this, however, the opposing groups do just that, oppose each other.

As it relates to the supply and demand of inpatient mental health care, differences in opinion are perhaps clearest in the context of state and federal funding. Looking first at the state-level, New York can be used as a case study. In the 2014 article, “Just Say No, Governor Cuomo,” D.J. Jaffe, executive director of the aforementioned Mental Illness Policy Org, warns against “ceding control of mental health policy to the mental health industry and offers a searing critique of Mental Health America for their support of the closing New York’s remaining state

psychiatric facilities (Jaffe 2014). In concurrence with the positions held by his organization, Jaffe argues that the funds saved by closing these facilities would be far outweighed by the cost incurred by a mass exodus of the state's SMI patients and the subsequent incarceration, homelessness, and crime. Further, Jaffe points out that while MHA and partner organizations vie for the funding that would be newly available, they lobby against initiatives such as Kendra's law, a stipulation of civil commitment law that would likely reallocate the burden of the patients with the most severe mental illness onto the community-based programs represented by MHA and NAMI. In effect, Jaffe implies these organizations leverage civil rights concerns applicable to the most needy patients, yet do not factor their care into a post-institutionalized future.

Jaffe's point is indicative of the divergence in focus between the contemporary traditional medical camp and total institution camp. Whereas the traditional medical camp prioritizes meeting the 50 inpatient bed goal and sees it as requisite to offer the most needy individuals a chance at recovery and society a chance at cohesion and order, the total institution camp broadly posits that the history of America's asylums have shown that recovery through inpatient care is fundamentally unattainable (NAMI 2020). Organizations such as NAMI and MHA hedge this position on three broad assumptions:

1. Mental institutions now are not functionally different than they were prior to the beginning of deinstitutionalization.
2. The organizing principle of mental institutions is not mental illness, rather it rests on tenets of custody and control, and civil commitment is the primary vessel of this. And;
3. By completing the push to deinstitutionalize, patients with serious mental illnesses who have long bore the brunt of poor treatment from institutional psychiatry will be better

off. For those with especially severe cases, however, ER crisis units, general hospitals, and private mental health facilities should be sufficient.

Evidence-based Policy Recommendations and Directions for Future Research

Without particularly validating the claims of the current traditional medical camp, this paper's findings suggest that several assumptions and concerns laid forth by Erving Goffman and the total institution camp do not appear to hold bearing to the current state of inpatient facilities nor do they warrant the abolishment of state funded inpatient programs. Specifically, mental institutions in the 20th century evidenced their function as straying from the treatment of the severely mentally ill through trends of great imbalance such as the times when they housed as many elderly patients with little need for inpatient care and unjustly committed minorities as they did mentally ill patients in need of their treatment.

Data analyzed in this paper showed limited imbalances in demographic characteristics of America's inpatient population. To the contrary, the most widespread characteristic of the sample was the presence of serious mental illness. Bivariate analyses further suggest inpatient facilities to be organized around the care of SMI patients—and not ulterior functions, social control and otherwise—through a large portion of the sample having multiple mental illnesses and the most frequently observed mental illnesses being the most serious (e.g. schizophrenia, bipolar, and depression). Additionally, bivariate analyses between racial demographics and mental health characteristics in the sample should serve to alleviate some degree of concern regarding the large-scale commitment of Black males without SMI. Ultimately, this paper shows mental health characteristics (i.e., disorder prevalence, severity, and type) to be the organizing principle of America's current institutionalized population. Most importantly, however, it suggests that hope

for mental institutions one day delivering on their original promise of asylum may be worth not giving up on just yet.

Practically this suggests, state and federal officials should not heed total institution ‘campers’ reasoning without conclusive evidence to suggest the continuation of illegitimacy of inpatient facility care on a large scale. Moreover, they should be wary of the effect of privatization on the most vulnerable. If state-funded inpatient options can no longer compete with the private-sector and Medicaid is not significantly expanded concurrently, inpatient stays of more than 1 night will ostensibly be out of the question for the working class mentally ill. Moreover, existing literature—ex. Snowden et al. 2019—suggests that an accelerated final push to privatize inpatient care would likely push low-SES and minority subpopulations of the mentally ill to homelessness and joblessness faster than the rest.

In addition to fighting for the retention of state and federal funds for public mental hospitals in budgetary negotiations, there are specific legislative actions that can be taken to protect the most vulnerable mentally ill individuals from losing access to inpatient care. Among those with the largest potential to improve the situation in a swift and meaningful way is the elimination of the IMD Exclusion (Mental Illness Policy Org). Writ large, the IMD Exclusion limits federal funding—via Medicaid—from being used to reimburse inpatient facility stays of individuals under the age of 65. At the state-level, rolling this measure back would alleviate strain on state governments’ healthcare budgets and cut away at the disincentivization of maintaining state inpatient facilities that is residual from the deinstitutionalization movement (Torrey, Entsminger, Geller, Stanley & Jaffe 2012). On an individual-level, it would dramatically increase the chances of adults who cannot afford private insurance to obtain inpatient care.

Future research should examine other elements of class status within inpatient populations, such as income and education, as well as the quality of care and post-institutional outcomes for those who are treated in America's inpatient mental health facilities. Moreover, if advocates of community-based care obtain sizable portions of current funding for state asylums, research on how to transition SMI individuals out of inpatient care and into community-based care will be crucial to keeping rates of crime, homelessness, and unemployment levels down.

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APPENDIX:



1. Drawing of Pennsylvania Hospital in *The History of Pennsylvania Hospital* (Morton 1895).



2. “Original Building of *The Retreat, York. Instituted 1792.*” Lithograph by Gemälde von Carve circa 1796. Sourced from York Civic Trust. Accessed Nov. 20, 2020.

(<https://yorkcivictrust.co.uk/heritage/civic-trust-plaques/samuel-tuke-1784-1857>).

3. Regression Analysis Output

		Variables in the Equation					95% C.I. for EXP(B)	
		B	S.E.	Wald	df	Sig.	Exp(B)	
								Lower Upper
Step 1 ^a	GENDER1(1)	.403	.004	9671.928	1	.000	1.497	1.485 1.509
	RACE1			5657.333	5	.000		
	RACE1(1)	.966	.016	3592.836	1	.000	2.627	2.545 2.711
	RACE1(2)	.226	.018	165.264	1	.000	1.254	1.212 1.298
	RACE1(3)	.508	.009	2995.749	1	.000	1.661	1.631 1.692
	RACE1(4)	.391	.040	98.039	1	.000	1.479	1.369 1.598
	RACE1(5)	.553	.008	4260.891	1	.000	1.738	1.709 1.767
	SMI1(1)	.303	.006	2984.645	1	.000	1.354	1.340 1.369
	Age Recoded			5576.439	2	.000		
	Age Recoded(1)	.330	.009	1293.706	1	.000	1.391	1.366 1.416
	Age Recoded(2)	.021	.009	5.115	1	.024	1.022	1.003 1.041
	Schizophrenia or other psychotic disorder reported(1)	-1.019	.005	49324.813	1	.000	.361	.358 .364
	Census region			17068.421	4	.000		
	Census region(1)	1.345	.055	604.587	1	.000	3.837	3.447 4.272
	Census region(2)	.219	.006	1265.768	1	.000	1.245	1.230 1.260
	Census region(3)	-.554	.006	8839.790	1	.000	.575	.568 .581
	Census region(4)	-.270	.005	2707.033	1	.000	.763	.756 .771
	Number of mental health diagnoses reported			9072.332	3	.000		
	Number of mental health diagnoses reported(1)	-.464	.009	2578.170	1	.000	.629	.618 .640
	Number of mental health diagnoses reported(2)	-.573	.006	9034.194	1	.000	.564	.557 .570
	Number of mental health diagnoses reported(3)	-.420	.007	3920.640	1	.000	.657	.648 .666
	Constant	-2.286	.015	24225.160	1	.000	.102	

a. Variable(s) entered on step 1: GENDER1, RACE1, SMI1, Age Recoded, Schizophrenia or other psychotic disorder reported, Census region, Number of mental health diagnoses reported.

3.a. Variables in the Equation

Hosmer and Lemeshow Test

Step	Chi-square	df	Sig.
1	1342.190	8	.000

3.b. Hosmer and Lemeshow Test**Model Summary**

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	1916146.378 ^a	.028	.068

a. Estimation terminated at iteration number 6
because parameter estimates changed by less than
.001.

3.c. Model summary