Lesson Plan Two:
A Brief Overview of the Asylum and Deinstitutionalization

HISTORICAL BACKGROUND

Introduction

The history of psychiatric institutional care begins in the 8th Century and the Islamic world of the Middle East and North Africa. In keeping with a belief that God loved insane people, asylums that offered patients special diets, baths, drugs, music, and pleasant surroundings were established in Baghdad, Cairo, Damascus, and Fez.

Conditions in Europe were very different. Throughout the Middle Ages, the Renaissance, and the Enlightenment, mentally ill persons were subjected to horrendous conditions. For example, the Hospital of Saint Mary of Bethlehem in London, which first admitted patients with mental illness in about 1402, was infamous for its brutal and inhumane treatment of inmates. By the 16th century, its nickname – "Bedlam" – signified any asylum or person who was mad.

A relatively brief period of improved care started in the late 18th century, when Jean-Baptiste Pussin, superintendent of a ward for "incurable" mental patients at La Bicêtre hospital in Paris, prohibited beatings and released patients from shackles. In 1793, Phillipe Pinel became chief physician at La Bicêtre, and he continued these reforms. He developed "moral treatment," a form of care that offered patients sympathy and kindness rather than cruelty and violence. In 1796, William Tuke established a model of compassionate care in rural England – the York Retreat where people with severe mental illnesses were able to rest, talk about their problems, and work. Practices in North America followed suit and, between 1817 and 1828, a number of "modern" mental institutions opened.

This period of benevolence did not continue for long. Care in psychiatric institutions deteriorated to mere custodial functions that provided patients with the bare requirements of subsistence in environments that were generally overcrowded and unhealthy. These conditions predominated in the mental hospitals of North America and Europe from the latter half of the 19th Century until the middle of the 20th.

Deinstitutionalization in the United States

Beginning in the 1950s there was an effort throughout the United States to remove long-term patients from psychiatric facilities and place them in community-based treatment programs. The impetus of this *deinstitutionalization* movement came from a convergence of several social forces. First, with the successes in treating soldiers traumatized by their

experiences in World War II, psychiatrists become optimistic about their ability to effectively treat mental disorders outside of hospital settings. Second, there was a growing feeling that the abusive conditions found in most state psychiatric hospitals, and the negative effects of long-term institutionalization, were at least as harmful as chronic mental illness itself. Many came to believe that the civil rights of people with mental illness were violated. Third, fiscal conservatives in the government were concerned with the enormous expense of caring for patients in large institutions. And finally, in 1954, the discovery of chlorpromazine, the first effective anti-psychotic medication, made it reasonably possible to manage the care of persons with chronic mental illness outside the hospital.

All together, these forces brought about a dramatic shift in admission and discharge practices at state and county psychiatric hospitals. The effects of these changes can be seen in the following data: in 1955, 559,000 patients were living in state and county psychiatric hospitals throughout the country. In 1980, only 138,000 people were living in such facilities.

The Effects of Deinstitutionalization

By virtually all accounts, the deinstitutionalization movement in the United States has been an utter disaster. Sociologist Christopher Jencks notes that good care is expensive, whether it takes place in a hospital or in the community.

“Deinstitutionalization saves big money only when it is followed by gross neglect.” In addition, the term *deinstitutionalization*, as it is applied in the United States, is a misnomer. *Dehospitalization* is a more accurate way to describe what took place. While long-term patients were discharged, short-term inpatient care increased. That is, the locus of care for those suffering from chronic mental illness did not change so much as patterns of care. Many patients were merely reinstitutionalized, placed in such settings as nursing homes and board-and-care facilities. Others were relegated to temporary shelters or single-room occupancy (SRO's) hotels. Worst of all, the criminal justice system has, for many persons, taken on the role of the old state hospitals. Citing jail as possibly "our most enduring asylum," Katherine Briar-Lawson, Dean of the School of Social Welfare at the University of Albany, has written:

> "When traditional pathways of care are blocked, the local jail becomes the recycling station for some deinstitutionalized persons. Like the old asylums, the jail increasingly functions as the one place in town where troubled persons can be deposited by law enforcement officers and not be turned away."

Recent estimates suggest that between 6 and 15 percent of those in city and county jails, and 10 to 15 percent of those in state prisons are suffering from severe mental illness. Indeed, the Los Angeles County Jail has been identified as the largest mental institution in the United States.

Since the 1970s, there has been fierce debate over whether deinstitutionalization has been a direct cause of homelessness among persons with chronic mental illness – who comprise only about one-quarter to one-third of the entire homeless population. One of the best accounts of the policies that brought about deinstitutionalization can be found in Jencks’ book, *The Homeless* . We recommend that students and teachers read this account to get a

fuller understanding of the issues.

In brief, there are two essential points to remember when considering the issues above. First, although the deinstitutionalization process began in the mid-1950's, a disproportionate number of mentally ill persons only began to appear among the homeless population in the mid-1970's. This lag of twenty years makes it impossible to claim that deinstitutionalization was the sole cause of homelessness among persons with chronic mental illness. Second, as originally planned, deinstitutionalization was to take place in conjunction with the establishment of community mental health programs that would take on the responsibility for the treatment of persons with chronic mental illness. President Kennedy signed the Community Mental Health Center Act in October 1963, which allocated federal funds to community clinics if they provided a full range of services, including out-patient, in-patient, and crisis services to persons with mental illness. However, these comprehensive community mental health centers were never adequately developed; neither were the supportive services (e.g., housing and rehabilitation programs) that are necessary for maintaining individuals in the community. Thus, neglect in the community took the place of abuse in the asylum.

QUESTIONS

1. From the depiction in *Imagining Robert*, do you think Robert was provided with "moral treatment" or "compassionate care" during any of his hospitalizations? What is your impression of the quality of care that Robert did receive?

2. Describe what is meant by custodial care. What factors do you think led to the deterioration of care provided in psychiatric hospitals?

3. In the film Jay said,

> "He's basically been in city hospitals, state hospitals, emergency wards, half-way houses, for 37 years now. The last 6 years he's been in this one hospital on isolation most of the time, day after day after day. . .And Hillside was the first place where Robert stayed long term. And this was the first of many. After this you were at Creedmoor on and off for four and a half years. You were at Mid-Hudson Psychiatric Center. . .You were at South Beach for many years. Gracie Square. Bronx Psychiatric Center. . .in between a lot of SROs."

How do you think the implementation of deinstitutionalization in New York affected decisions made about Robert's treatment?

4. How might living in a psychiatric institution for years at a time affect a person's behaviors, attitudes, self-esteem, and hopes for the future? How might it affect a person's socialization skills? What do you think has been the impact on Robert of his many hospitalizations?

5. How might long-term hospitalization affect the family of a person with chronic mental illness?

6. What is meant by the civil rights of patients? Based on the information in the film, do you think any of Robert's civil rights were violated when he was hospitalized?

7. How do financial concerns shape mental health policies?

8. Community programs can only be effective if people use their services. Why might a person with chronic mental illness choose not to go for treatment or decide to discontinue taking medication? Debate the pros and cons of whether people with severe mental illness should be forced to take medication.

9. What are the reasons that people become homeless? How might mental illness play a role? Do you think it is the most important factor?

10. How has jail become a replacement for asylums?

11. Who do you think needs to be included in decisions about the implementation of community programs for the chronically mentally ill? For example, how might you include police and judges? What should be provided for the families of those with chronic mental illness?

RESEARCH PROJECTS

1. It is now recognized that people with chronic mental illness have a number of specific rights. What is meant by: the right to receive treatment, the right to refuse treatment, informed consent, and the right to receive the "least restrictive treatment" available? Learn about the *Wyatt v. Stickney* and the *Lynch v. Baxley* cases.

2. Where are persons with severe mental illness hospitalized in your community? How long have these psychiatric hospitals/units existed? Are they public or private? What is the cost of hospitalization in each?

3. What is the average stay of a patient on the inpatient psychiatric units in your area? What was the average stay ten years ago? Thirty years ago? What do you think has brought about these changes?

4. How many state-run psychiatric hospitals are there in your state? What is the current census? How many state-run hospitals were there in 1960? What was the census then? Learn more about one state-run psychiatric hospital, Northampton State Hospital, Northampton, Massachusetts, at the following website: www.1856.org

5. What is your health coverage for the treatment of severe mental illness? How does it compare to your medical coverage for physical illness? Where would you seek care for mental illness if you had no insurance?

6. What does parity mean for health insurance coverage? What is the status of parity legislation in your state?

7. Where do persons with severe mental illness live in your community? Are there half-way houses, independent living arrangements, foster families, nursing homes, SRO's, etc? Where are they located? Who funds these programs? How much does each living situation cost?

Are there time-limits for length of stay? Learn more about Project Renewal, Robert's current home, at: www.projectrenewal.org

8. What kinds of community mental health programs are there in your community? For example, is there a 24-hour crisis service, a day or partial hospitalization program, etc.? Are vocational and rehabilitation programs provided? Where are they located?

9. What is the NIMBY effect? What has been the impact of this attitude? Use newspapers, minutes of city council meetings, etc. to find out whether there were controversies when community programs were first proposed in your area. See the articles about conditions of homes for the mentally ill in New York referred to in Lesson Plan 1.

10. What is the Clubhouse movement? Learn more about Fountain House, the clubhouse in which Robert participates, at: www.fountainhouse.org

11. What is the "revolving door" syndrome? How did it come about because of deinstitutionalization?

TAKE ACTION PROJECTS

Students can become advocates for persons with mental illness in a variety of ways:

1. Students can volunteer to work in programs for people who are mentally ill.

2. What ideas can students generate for providing education and information that might change the attitude of NIMBY? How might they implement these ideas?

3. Since care for persons with mental illness is now in the community, rather than in hospitals, mentally ill persons and their advocates have become more visible and powerful. Have students learn what forms of advocacy are taking place by attending meetings of advocacy and consumer groups. They can use what they learn to become involved in campaigns to end discrimination and stigma, increase funding for treatment and research, and widen access to supportive services in the community. The following sites will also be helpful:

National Mental Health Consumer's Self-Help Clearinghouse
www.mhselfhelp.org

National Mental Health Association
www.nmha.org

National Alliance for the Mentally Ill
www.nami.org

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