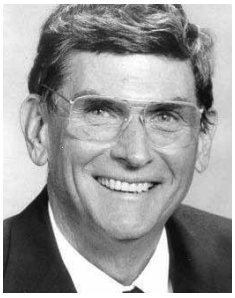
Closing the Asylums: The Causes and Continuing Consequences

By George Paulson



George W. Paulson, M. D., Emeritus Professor of Neurology at The Ohio State University, was the founding Chairman of the Department of Neurology, and formerly the Chief of Staff of OSU Hospitals.

A graduate of Yale and then Duke Medical Center, he served as Kennedy Professor at Vanderbilt and Peabody Teachers College before coming to Columbus in1967.

In the past 40 years, and while in Columbus, Dr. Paulson served as medical advisor for support groups working to help individuals with multiple sclerosis, tuberous sclerosis, epilepsy, mental retardation, neurofibromatosis, and several movement disorders. He is now retired from clinical practice.

He is particularly proud of his five children, of his twelve grand-children, and of his wife of over 64 years, Ruth, a retired academic dentist and also "Emerita" from OSU. She usually makes him behave.

He joined the Torch Club because he admired so many of its members, and because he remembered how much his father enjoyed the Torch Club in Raleigh, North Carolina.

Asylum closing began in the late 1950s and accelerated over the following decades. Several hundred thousand hospitalized patients, many of whom were chronically mentally ill, were simply released. As a result of the deinstitutionalization, state hospitals were replaced with community mental health services. The large state hospitals, those big units that once housed half of all hospital patients in America, were virtually eliminated. In addition to the hospitals being totally disestablished or markedly downsized, facilities for the mentally handicapped, formerly labeled "retarded," were later similarly reduced and the residents, now referred to as "clients," were transferred to group homes, returning to local or family care.

This was no minor change; there were 558,235 patients in the major state hospitals in 1955, and that number was reduced to 71, 619 by 1994. If the institutionalization rates normal in the early 1950s had continued unchecked (according to E. F. Torrey, one of the leaders in community psychiatry), the total number of institutionalized patients, given population growth, would now be over 880,000.

We can rejoice that there are fewer strait jackets and less physical restriction, and no one wants to see a return of multiple confining cribs and locked and padlocked doors. But what became of all those former patients, and why was there not a more gradual transition? This review will discuss some of the causes, unintended consequences, and aspects of the changes. As we contemplate the various results of this profound transition, perhaps we can consider other future potential options.

* * *

My book *Closing the Asylums*, published in 2012, was inspired in part by my teenage years of watching ill-clad women clutching an old wire fence that surrounded part of the over 2300 acres we called "Dix Hill," recently renamed the Dorothea Dix Hospital. The Dix name honors the woman who established over a dozen similar institutions in an enlightened effort to get the mentally ill and severely handicapped out of jails, basements, and chains and into more nurturing, civilized surroundings. Because of her remarkable efforts, including caring for the terminally ill wife of the North Carolina Speaker of the House, Dorothea Dix succeeded in creating the first North Carolina mental hospital in 1840. She

insisted that the hospital be named Dix Hill for her grandfather, not her. Dix Hill once consisted not only of the hospital, but also of farm land, fish ponds, and meadows in the countryside outside Raleigh, the state capital; by the mid-1900's, though, Dix was totally surrounded by the capital city. The Dix land has now been turned over to nearby North Carolina State University and is used for food markets, parks, and development. It once housed over 2500 patients, albeit inadequately. Now there are none.

In the 1960s, I served as the neurologist at Dix and also, more recently, at the once similarly crowded "Hilltop," called the Columbus Lunatic Asylum when it was founded in 1835 and later renamed the Columbus State Hospital. What remains is the Twin Valley Behavioral Healthcare facility, a small unit with only a residual 230 patients, perhaps half of whom are "forensic" cases, meaning they were admitted by a judge and are held for legal as well as for psychiatric reasons. Facilities that once housed—some would say, "held"—thousands of patients are now no more.

Until the 1970s, Hilltop included units for over 2400 persons: the senile elderly plus schizophrenic patients, mentally disturbed teenagers, alcoholics, and the mentally ill who also had tuberculosis. It even contained a unit for the mentally ill deaf. The patients once had access to two conservatories, regular movies, and a chance for many to walk around the grounds. There was active farming at the foot of the hill, and, in fact, the institution could hardly have run without the work of patients responsible for repairs, cleaning, and food preparation. Twin Valley still sits on the beautiful hill to the west of Franklinton, once a small village but now a suburb of Columbus. Similar stories occurred not just in Raleigh and Columbus, but all across the land.

Farms were attached to most of the large state hospitals and work was considered therapeutic. During the Great Depression, the inmates were better fed than many who lived outside.

Around the country there were similar institutions, usually in the countryside in what was termed a "salubrious" environment, all offering programs designed to protect the helpless and provide therapy for the mentally ill, but surely also to assure separation of the patients from the public. Farms were attached to most of the large state hospitals and work was considered therapeutic. Surplus produce from the Hilltop was actually sold. In fact, during the Great Depression, the inmates were better fed than many who lived outside.

The architectural design of these institutions was often specialized, unique to their purposes. Many similar to the Hilltop had multiple wards and wings of the Kirkbride pattern, with gender separation and separate areas for the elderly "senile" patients and those who were acutely demented or violent.[1] Dix Hill had separate cottages, the proposal of planners who sought more of a community feeling for confined patients. But some who urged closure of the old large facilities pointed out that they were, in essence, plantations—with keepers and the kept, custodians and the subservient, and a hierarchy even among the patients and attendants. Others saw and rejoiced in patients being able to be free on the grounds, work in the conservatory, regularly participate in games and entertainment, and even eat meals along with staff who often lived on the grounds and knew the "inmates" as individuals.

* * *

Deinstitutionalization was enabled by one of the most fundamental changes in psychiatric care in the twentieth century, the development of effective

psychotropic drugs. Releasing patients and letting them return to their communities, even without being fully cured, was more feasible because of the availability of medications that ameliorated the most severe of their symptoms.

Other factors were also at work, however, and deinstitutionalization actually began before the drug revolution was fully underway. Advances in medical care and public health meant that fewer children were brain damaged at birth or by infections. There were also fewer people with brain injury from industrial accidents. Conditions like tuberculosis, which required a full building at Dix in the early 20th century, responded to medication and therefore prolonged isolation no longer seemed necessary. Alzheimer's disease was better recognized, and nursing homes became both available and economically viable. There were new programs for those with strokes, paralysis, and head trauma, plus new locations for physical and occupational therapy. In Gallipolis, Ohio, an entire institution was built in 1894 to house and treat epileptics, the first location in America to do so. By the early twentieth century it held over 1400 patients, but anti-seizure medications became much more effective, and subsequently all the cottages were closed.

Public perceptions of the institutions were changing as well, usually for the worse. In 1946, *Life* magazine published distressing photographs from inside Philadelphia's Byberry Mental Hospital—a place considered a hellhole by some who had never worked there and never even visited but were, nevertheless, convinced it was really a prison operating with a medical label. Writers who had once been patients and conscientious objectors who served in mental hospitals during World War II wrote revealing articles. During the 1950s, there was increasing concern about freedom for the mentally ill, and the individualism movement of the 1960s only intensified the debate. Attitudinal shifts in society reflected the effect of movies like *One Flew over the Cuckoo's Nest* and Thomas Szasz's book decrying the "myth of mental illness." Standard and effective psychiatric therapies, including ECT and what some called the "chemical straitjacket" effect of anti-psychotic medication, could be classed as barbaric.

Public perceptions of the institutions were changing as well, usually for the worse.

An additional factor was the prevailing conviction that even the most severe psychiatric symptoms were produced not by organic or hereditary factors but rather misguided familial and social factors. Freud was dead, but Freudian concepts were not, i.e., perhaps if we just brought about necessary societal changes, mental illness would just disappear

The social pressures generated by such concerns led to the establishment of the National Institute of Mental Health. One of its early directors, Dr. Robert Felix, vigorously denounced the large mental hospitals. President John F. Kennedy, whose handicapped sister had been harmed by a lobotomy, signed legislation to assure "the decrepit and costly anchors of mental health in this country were to be supplanted by Community Mental Health Centers" (Kirk 544). Indeed, a bill for nursing education specifically stated that no federal money was to be used to preserve the large state hospitals.

Other roadblocks were set up, making institutionalization of the mentally ill extremely difficult. For example, there were successful lawsuits insisting that a mentally ill person, in or out of hospital, was entitled to any care needed. Multiple legal cases confirmed the right to a full legal hearing even for a person involuntarily confined. Adequate personnel and ancillary help were made mandatory for those confined. But, "mental illness" was not considered an adequate indication for admission, nor was "dangerous thought" without dangerous action sufficient grounds to confine persons. Therapy, by law, had to be in the least restrictive environment. Consequently, the hospitals had no choice but to close, and community centers became the alternative. But—and this can be no surprise to anyone—funding continued to

be inadequate, and new funding for building new centers did not include adequate funds for staff.

The deinstitutionalization trend was thus already in place when the drug revolution arrived to accelerate the process. The presence of useful drugs to control symptoms of severe psychosis suggested to legislatures that there was no longer any need to increase funding for mental illness, even though funding had always been inadequate.

* * *

So, out in what was once bucolic countryside where some of those magnificent old buildings still sit, urban sprawl now surrounds many of them. Most had never been really adequate as hospitals, and the national criteria for wards, privacy, and toilets have changed.

At Hilltop and many other places, there was a process of demolition by neglect. Even though the Hilltop building was declared a historic preservation site, it would have taken over $50 million of state dollars to repair it, and mentally ill patients are never going to constitute a major voting bloc. Also, over time, staff stopped living on the grounds. In addition, legal and union protests in Columbus prevented continued patient employment to help maintain, feed, and clean the big institution. Moreover, more than one entity was aware of other uses for that now valuable land, 350 acres in Columbus and those 2300 acres in Raleigh.

What now happens to the mentally ill who once would have been housed and treated in facilities like Dix Hill and the Hilltop? Twin Valley Behavioral Healthcare still has close to 2000 admissions per year, a number greater than in 1950, but the stays are much shorter, the average length of stay for non-forensic patients being between 12-20 days, not months or years as before. Elderly mentally ill patients are not commonly admitted, and nursing homes now house most of them. There are very few patients walking the grounds. There is continued concern about the revolving door phenomenon, with some patients going in and out a dozen times as they improve dramatically on medication, then stop therapy, and again have to be picked up by police.

At Hilltop and many other places, there was a process of demolition by neglect.

Undoubtedly, some of patients who were released as the big state hospitals faded from the scene did well, and some families coped adequately with the new situation. However, mental illness has certainly not disappeared, and there is now increasing concern about substance abuse. At present in an emergency it is often easier to call the police than to find a psychiatrist, even though there are many busy mental health clinics, hospital units, plus over 250 group homes in Columbus that are often housing former patients. While it would be wrong to blame all of homelessness on deinstitutionalization, as there has always been restlessness, vagrancy, poverty, and substance abuse—all major contributors to homelessness in America—it is undeniable that deinstitutionalization was linked to an increase in homelessness, with the deinstitutionalized sleeping on vents or under bridges. One night in January 2008, 664,414 homeless persons were in shelters or "unsheltered," and by all estimates, up to 25% of them had a mental disorder. Many hold that jails have become the new mental hospitals as 20-30% of prisoners have mental illness.

This physician has opinions, biases if you will. I think that young physicians, before beginning to practice, should have observed numbers of severely mentally ill persons, as they once did as students or while serving internships in the large mental hospitals. I wish practicing physicians and psychiatrists were as well compensated for treating the mentally ill as for treating the "worried well." I am sure that for some people, mental illness is as organic as heart disease and should be approached in research and therapy with as much enthusiasm as for any other organic disorder. I am convinced that, unfortunately, there are some of our citizens who will never be able to be fully self-

supporting, and our capability as a society to cope with this endless human problem is one of the ways we should be judged.

Here are questions perhaps you can answer. Did the presence of more homeless on the streets make society more or less tolerant of those with mental illness? Is there less stigma attached to mental illness now?

There are conceptual advances we hardly notice. For example, the psychiatrists properly speak of "recovery," so as not to imply a full cure but rather the sustaining of the patient in as healthy a mental state as is possible, never a pretense of perfection, but reality and hopefulness. Among additional future changes I expect are:

- Federal efforts and regulations increasing, not diminishing.
- Physicians increasingly working as hospitalists or state employees or even as part of large corporations.
- The private psychiatric hospitals continuing to wither, with new smaller units perhaps appearing.
- Psychiatry and neurology tending to merge and being renamed "behavioral therapy" or "cognitive studies" or some such euphemism.
- Nurse practitioners and laypersons with varied labels continuing to deliver the bulk of the care.
- Better biological markers for mental illness, and as with other organic processes, and definitions and therapies will be more closely linked to the disease process.

For me, some of the most interesting aspects of my professional life included work in mental hospitals, and some of the most rewarding moments were with staff and patients in those facilities. But then I have always been lucky, far luckier than the man sleeping on a park bench or huddled in a homeless shelter or plagued with demons that seem more real to him than are those who love him. We should never forget that unfortunate fellow.

NOTE

[1] The Kirkbride plan is named for the 19th century physician Dr. Thomas Kirkbride. "A Kirkbride Plan building consists of a center section for the hospital administration and (in the early days) a living area for the superintendant and his family. Behind and to either side of the administration section are 'wings' that contain patient wards. The patient wards staggered out and back from the administration section. From the air the building would look like a 'V' or a 'bat wing'. [...] The Kirkbride Plan allowed for many other advantages over previous building styles. It allowed for maximum amounts of light and ventilation into the patient wards." (Wikipedia).

WORKS CITED

Dear, M.J., and Wolch, J.R. *Landscapes of Despair: From Deinstitutionalization to Homelessness.* Baltimore: Princeton U P, 1987.

Howard, E. *Homeless: Poverty and Place in Urban America.* Philadelphia: Temple U P, 2013.

Kirk, Stuart. "The Evolution of a Federal Agency." Carol S. Aneshensel and Jo C.

Phelan, eds., *Handbook of the Sociology of Mental Health.* Springer, 2006.

"Kirkbride Planned Institutions." Wikipedia.

Paulson, G. *Closing the Asylums.* Jefferson, NC: McFarland, 2012.

Szasz, T. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct.* First published 1960. NY: Harper, 2010.

Torrey, E F. *American Psychosis: How the Federal Government Destroyed the Mental Health System.* NY: Oxford U P, 2014.