From Beauty to Despair: The Rise and Fall of the American State Mental Hospital

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Abstract The American State Hospital has survived over 200 years. Society once viewed state hospitals as an absolute necessity and each state constructed numerous hospitals. Over time, the image of the state hospital as a means to cure the mentally ill changed drastically. The public perceived state hospitals as snake pits that warehoused the mentally ill and the state hospital was nearly destroyed. Nevertheless, the state hospital remains today with purposes similar to its ancestors and some that are very different. This paper examines the many influences that created the state hospital. Additionally, this paper addresses the Kirkbride Model, treatment methods and practices over time, and how the state hospital fell into disfavor as a means to treat the mentally ill. The paper concludes with comments on the mental health system today, in relation to the state hospital’s role in treatment.

Keywords Moral treatment · State hospital · Asylum · Kirkbride Model · Deinstitutionalization

The American State Hospital survived over 236 years (1773–2009) despite its tumultuous history. Asylum, in its original sense meant a safe haven; it was a place one could go to be safe from hurting others and one’s self. Today the word asylum is largely disputed, but mostly associated with a negative connotation when referenced to the treatment of the mentally ill. One image is of a medical institution infused with humanitarian values and the other is of a prisonlike structure with a sole purpose to confine the insane [30]. American history influenced what the state hospital or asylum was, and what it would become. At times it was a place where moral treatment occurred, and at times it was a custodial institution. This paper will review the factors that created a need to treat the growing numbers of mentally ill persons in America. The most encouraged treatment option ultimately became the public asylum. Proponents of the asylum, such as Dr. Thomas Story Kirkbride believed that home treatment of the insane could not compare to that of a well
organized hospital [17]. In addition to discussing the creation of the state hospital and its rise to popularity, its near demise will be addressed. In the process, factors such as moral treatment, reform, reformer, treatment techniques and daily life will be reviewed. First, however, one must address a quick note on terminology.

The terms used to describe what we call mental illness and its treatments did not exist 250 years ago when America was learning about them. Such terms changed over time as science progressed and social and political reform as well [10]. It is not possible to use the language of today to describe problems of the eighteenth and nineteenth centuries. Tomes [30] states the generations that created pioneering treatment options for the mentally ill preferred the terms insanity, asylum doctor and asylum medicine. Additional terms such as lunacy, lunatic, and madness described the insane. Gamwell and Tomes [10] point out that lunacy containing intermittent derangement was believed to be caused by the phases of the moon, whereas the term lunatic was created for legal purposes, preventing a person from interring into legal contracts. Madness was defined as wild, deranged and with little emotional control. To avoid any confusion these terms will be used to discuss the creation of the America state hospital. As history progresses, the terms used to describe the mentally ill and mental illness will also progress.

**Early Perspectives on Insanity**

To understand what the situation of people without hospitals for the insane was, it is necessary to learn what their condition was when there were none [17]. Prior to the 1700s American colonists looked to religion as an explanation for madness. Mather, a minister in colonial Massachusetts, was one of the first to address madness from a religious perspective. Mather wrote that Satan himself caused turmoil and melancholy [13]. In addition to religion, other explanations were available. Hippocrates created the idea that an imbalance of humors in the body caused certain human behaviors. An imbalance of humors, blood, phlegm, cholera (yellow bile) and black bile, would thus give a person various ailments [10]. An imbalance of humors was one of the few available medical explanations for madness and would preside until the middle of the eighteenth century. During this time, families and communities cared for the insane [13]. Communities during this time were small; persons had a vested interest in survival and looked to their neighbors for help. Families would help each other when the issue of insanity or eccentricities arose. Grob [13] states that it was common for towns to provide subsidies to families dealing with an insane family member, as it was often emotionally and economically draining. If families were unable to care for their insane or did not have the financial means, many ended up in jails or public poorhouses [13]. By 1766 there was a public outcry for better solutions to treat the insane. Virginia’s Royal Governor, Francis Fauquier, proposed at the House of Burgesses to create a hospital to treat idiots and lunatics. Kennedy [16] reports that the Governor added these were:

> 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, who cannot help themselves. Every civilized Country has an Hospital for these People, where they are confined, maintained and attended by able Physicians, to endeavour to restore to them their lost Reason. (p. 12)
In 1773 the Eastern Lunatic Asylum of Virginia (Eastern State Hospital) opened in Williamsburg, Virginia as the first American public asylum to treat the insane. Grob [13] states that the hospital did little more than care for the insane without providing any real treatment. The idea of an institution outside the family or community to help treat the insane was new, but many other ideas about social change, science and technology were developing at this time.

Factors Contributing to the Creation of the Public Asylum

As the nineteenth century began, Europe’s enlightenment peaked in America. Knowledge inspired Americans who sought out science and reason [11]. With enlightened ideas came new approaches to treat madness. Physician Benjamin Rush looked to science and medicine for an explanation of madness. Rush, often credited as the father of American psychiatry [8] believed that a disorder in the vascular system caused madness. In his medical publication, Medical Inquiries and Observations upon the Disease of the Mind [25], Rush prescribed that the veins be opened to restore an imbalance of blood. Used for thousands of years [23], bloodletting became popular as a method of reducing over-excitation in insanity [10]. With the Enlightenment came new technologies. America moved from rural, scattered towns to large urban cities. In the cities, factory and business work became common, thus creating a separation of family and profession [13]. This separation redefined the role of the family which no longer had the support to care for their insane. Grob [13] adds that with the increase in population during this time came a proportionate increase in the numbers of insane persons. The public looked to social institutions for a solution to the growing numbers of insane that were especially prevalent and visible in more densely populated areas [13]. In addition to an increase in population, Yanni [34] writes that the demand for hospitals increased because it became more socially acceptable to have family members committed. At this time Enlightenment ideals influenced Philippe Pinel, who would make significant medical changes to the treatment and perception of the increasing numbers of insane.

During this time hospitals and asylums did exist in America, but were few in number and their role in treating the insane was not well defined. Many insane were confined to prisons, jails, poorhouses, and almshouses. Germian et al. [15] reports that in 1843 there were 794 paupers in New York; 630 were not being provided for. By 1853 1,856 paupers resided in New York with 1,562 not receiving care. Philippe Pinel argued that a medical approach was necessary to treat the insane; his approaches, as Grob [13] points out, would have a significant impact on the creation of formal asylums. Pinel disapproved of bleeding, punishment and restraint as these treatment options did not help the insane. In his Treatise on Insanity, Pinel [24] argued that it was out of convenience for the hospital superintendent to allow lunatics to be restrained and in constant seclusion. Pinel [24] proposes that insanity not only has physiological causes, but psychological causes as well and was curable. He offers the idea of traitement moral, which sought to gain the person’s confidence and instill hope in their treatment. In America this became known as moral treatment. Moral treatment, according to Pinel [24], required one to be placed in a well ordered asylum. Pinel believed that the physician would hold the dominant role in the asylum and would seek to break skillfully the will of the insane person so he would not object to the treatment the physician prescribed. America had to wait for Pinel’s works to be translated into English. Once this occurred his works were well received. While Pinel played a crucial role in confirming the necessity for asylums, others made significant contributions to the field as well.
Among the major contributors were Benjamin Rush and William Tuke. Benjamin Rush, as previously stated, helped alter theories of madness and created new techniques to treat it. William Tuke, an English Quaker, founded the York Retreat in 1792 [10]. Tuke’s therapeutic techniques were similar to what Pinel called for in his moral treatment. Gamwell and Tomes [10] add that the overall goal of the York Retreat was to help the insane develop internal means of self control without the use of drugs or bleeding. The idea of instilling hope in the insane is consistent with treatment of the mentally ill today [29]. Dr. Kirkbride [18], a prominent psychiatrist, noted the contributions of Pinel and Tuke in the creation and defining of moral treatment, which Kirkbride would use himself at the Pennsylvania Hospital for the Insane. The contributions of Rush, Pinel and Tuke provided the utmost justification for a medical based system where only asylum doctors could apply treatment for insanity.

The Creation of the Public Asylum

As the evolution from heterogeneous treatment options to a unified idea of treatment for insanity became closer, Dr. Thomas Story Kirkbride provided a model. In 1756, the Pennsylvania Hospital opened with the help of financial contributions from Philadelphia’s elite [30]. This hospital was a general hospital for all ailments, including insanity. In the early days, physicians placed lunatics in the basement of the hospital in barred cells while violent patients were restrained with straight waistcoats, mad shirts, or iron chains [10]. The hospital did little to actually treat their insanity. To meet the growing demand for its services, the Pennsylvania Hospital built several additions to its original structure. With an annual cure rate of 17 percent, the hospital became crowded and state legislatures required new methods of control and treatment [30]. Finally, in 1841, the Pennsylvania Hospital for the Insane opened, with Dr. Thomas Kirkbride as the Chief Superintendent. The new hospital was one of sixteen hospitals in the country that operated under Pinel’s moral treatment [13]. The hospital, built two miles outside the city of Philadelphia, had over one hundred acres of land around it for patients and attendants to use [30]. Kirkbride would spend the next 40 years developing what would become the Kirkbride Model, which public asylums in America would model their institutions after [30].

In Kirkbride’s [19] book, *On the Construction, Organization and General Arrangements of Hospitals for the Insane*, he defined the requirements for a well ordered asylum. Yanni [34] states that the Kirkbride plan was distinctive: no other nineteenth-century American institution used a plan like it. The Kirkbride Model consisted of a hospital that was on the outskirts of a moderately sized town, accessible by railroad, with much land for farming and gardens, the idea that the asylum would be self sustaining [30]. The hospital would be linear with symmetrical wings coming off a central administrative building (see Fig. 1), with a minimum of eight wards per wing [19]. The wings allowed for proper ventilation and light to reach every part of the hospital, an essential concern for Kirkbride. The model called for large windows especially in day areas and solariums; additionally, bars on windows prevented patients from escaping and helped secure the asylum [19]. The most violent patients resided on the first floor as far from the central administrative building, usually toward the outmost wing, to not agitate the more calmed patients. Kirkbride [19] adds that it is “important that the building should be in good taste, and that it should impress favorably not only on the patients…but others who may visit” (p. 11–12). Kirkbride instituted therapeutic beauty to his plan for hospitals; there would be gardens, fountains, trails, and a grandiose architecture that remains impressive today. Kirkbride’s
plan was to make the hospital look as attractive and impressive as possible to reassure and calm the patients, while bolstering support of family members who committed their loved ones [30]. The Superintendent’s faith that architecture and landscape had the ability to cure insanity is difficult to understand but helps to explain the massive structures that were being constructed in America [14]. Kirkbride did not neglect security, it remained a chief concern; with appearance its second most important concern, Kirkbride sought to proof the hospital to withstand wear and tear [19]. Tomes [30] sums up that the Kirkbride Model covered every painstaking detail one needed to construct and run an asylum. As previously stated, immigration increased dramatically in the nineteenth century, and many asylums were built with the Kirkbride Model to meet the increased demand for their services.

One of the new public asylums built in 1833, Worcester State Lunatic Asylum, provided a culminating model for the rest of America. In Massachusetts, several hospitals were already in existence, but there was still a growing demand for more [13]. A central problem was that, of the hospitals that existed, many were privately funded by philanthropists. Concerned about the poor who could not afford private asylum treatment, the state legislature in 1830 agreed to appropriate funds for the creation of Worcester State Lunatic Asylum (Worcester State Hospital). Dr. Samual B. Woodard was appointed superintendent of the asylum. Woodard created an ideal asylum using moral treatment and the Kirkbride model, which public asylums all over the country would recreate [13]. Woodard and Kirkbride were two of thirteen asylum doctors who helped found the Association of Medical Superintendents of American Institutions for the Insane, known today as the American Psychiatric Association [10]. Woodward’s example at the Worcester asylum was the epitome of what the state hospital was supposed to look like and operate. Asylums around the country looked to Worcester as an example to model their asylums after. With the implementation of moral treatment, a belief that the asylum could cure the insane, the Kirkbride Model and a dramatic increase in insanity, the public asylum was built with fervor the last half of the nineteenth century.

Reform of Insanity and Campaigning for the Asylum

During the 1840s through the 1860s asylums all over America were constructed. By 1880, almost 140 asylums were built [34] and by 1890 at least 70 were constructed according to the Kirkbride Model [30]. A compassionate and humane Dorothea L. Dix took the lead in petitioning and campaigning for states to fund institutions and improve the ones they had.
Grob [13] adds that Dix’s insistence of the need for large scale institutions for the insane agreed with the public outcry directed at social institutions. Dix gave the public what they wanted: an answer to the problem of how to handle their insane.

Dorothea Lynde Dix was born on April 4, 1802 and spent her early years teaching children and offering assistance to the poor in Worcester, Massachusetts [28]. Dix failed to follow the traditional career trend of becoming a teacher or nurse for women of her time. In 1836, Dix suffered a breakdown due to nerves and exhaustion; it was at this time that she met the Rathbone family in Liverpool England whom would take care of Dix until her health returned [28]. The Rathbone family introduced Dix to the ideas of social reform aided by the government and the British Lunacy reform movement. Dix spent nearly 18 months abroad and returned home in the fall of 1837 [28]. Upon her return Dix had a new purpose. Grob [13] explains that Dix spent over a year traveling throughout Massachusetts inspecting the conditions that the insane were confined to. In Dix’s [6] *Memorial to the Legislature of Massachusetts*, she writes:

> I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane, and idiotic men and women’ of beings sunk to a condition from which the most unconcerned would start with real horror…(p. 1)

Through compassion, knowledge and determination, Dorothea Dix insisted that the state had an obligation to care for these persons and the asylum was the proper way to do so. Grob [13] adds that Dix became a specialist in the field of institutional psychiatry and held power in deciding asylum superintendents, settling internal disputes, and even helping young doctors decide on asylum careers. Viney and Zorich [31] add that Dix’s impressive career brought about much reform in the treatment of insanity as well as the creation of 47 asylums around the country. By the second half of the nineteenth century, care for the insane in asylums was the consensus among the public and medical community.

**Patient Life and Treatment in the Asylum**

The life of a patient in a public asylum was one of regiment. Since most public asylums operated under the Kirkbride model and moral treatment, which called for strict regimen, that is what was administered. Patients would rise early for medications and breakfast. At this time the asylum doctor made rounds to check on all the patients and make appropriate adjustments as needed. After breakfast all patients would engage in activities of various sorts to not be idle. All able patients were to take at least one 20 min walk on the hospital grounds [30]. The hospital provided games, a library, and even a gym. Many superintendents, such as Dr. Francis Stribling of Virginia’s Western Lunatic Asylum, believed in the value of work to avoid making the mind idle. It was considered therapeutic but was not forced onto the patients [33]. As a self-sufficient institution, the availability of work was abundant. Wood [33] adds that female patients would darn and mend clothing for staff and patients as well as knit stockings, socks and sew all types of clothing. Able male patients farmed, worked manual labor such as clearing snow in the winter or worked in the green houses to cultivate all the plants for the wards and property grounds [27]. Patients usually did the same kind of work in the asylum as they did before arriving there. Besides working,
patients participated in a number of other activities that pertained to their treatment. Patients received nutritious meals and appropriate hours of sleep. Ward assignments were used as incentives for good behavior and could be earned or taken away, similar to a token economy. Attendants helped with the previously described day to day routines and were with patients at all times [30]. Attendants also had an important job of modeling good behavior and social skills for the patients to observe as part of their moral treatment as well as always treating patients with kindness and compassion. When nutrition, sleep, exercise, talk therapy, hydrotherapy and good modeling failed to work on seriously insane patients (with psychosis or mania), other methods were ultimately deployed such as seclusion and restraint.

Many patients received drug therapy of some sort, usually in the form of narcotics, specifically morphine. When administered by the asylum doctor, morphine treated manic symptoms, lifted one out of depression and weakened delusions [30]. Additional remedies prescribed by asylum doctors were chloral hydrate, a derivative of chloroform, cups to treat mania, cathartic pills for melancholy and laxatives to treat constipation [30]. If drug therapy had no effect treating violently insane patients, most asylum doctors had to resort to physical restraint as stated. The moral therapy model, as previously described by Pinel, strived to minimize physical restraint, letting patients have their freedom to move about and learn from their environment. Kirkbride, in treating the insane at the Pennsylvania Hospital, made use of seclusion and restraint in the form of sleeves, bed straps, and canvas shirts [17]. Kirkbride understood the risks and pervasiveness of restraint; it was only used as a last resort for the minimal amount of time necessary. [30] adds that force feeding patients was also practiced but only when necessary.

Patients were reluctant, however, to even enter an asylum. [13] points out that on some occasions it took a great deal of coercion from the family and asylum doctor for one to enter into the asylum. Additionally, patients in asylums did not always comply to prescribed treatments as many were severely insane or simply did not want to be in the asylum. Many patients would engage in self-mutilation, violence against others, destruction of property, filthy habits such as masturbation or smearing, or elopement [30]. Behaviors such as these left asylum doctors and attendants extremely busy. Superintendents such as Kirkbride and Stribling understood the difference between troublesome patients and those too insane to understand their actions. Unfortunately the ideas and theories that Kirkbride, Pinel, Tuke and Rush campaigned for would not last long. Asylums were not able to operate under the previously described conditions for too long.

An Institution in Trouble

The accumulation of chronic insane persons in public asylums in the late nineteenth century, combined with extreme financial burden, caused an eroding of support for the asylum [30]. State legislatures originally agreed to build public asylums to meet demand but failed to consider the costs of operating budgets. Soon after their construction, asylums were in desperate need of money. Originally designed to be self-sufficient in nature the asylum still required outside funding for appropriations such as payroll and electricity. Grob [13] points out that in the mid-nineteenth century hospital construction became dependent on the economy and how cheap the hospital could be constructed; sometimes by eliminating day rooms, furnishings, and relocating water closets and bathing facilities.

As the population increased in America, so did the insane. In 1860 the population of the United States was 31.4 million and the patient population in asylums was roughly 8,500
By 1890 the population in the United States doubled to 63 million and the patient population in asylums increased ninefold to 75,000 [2]. Asylums, from their very beginning, faced increased pressure to expand. Growth of population led to larger asylums being constructed which had a toll on the ability to control regimen and moral treatment [13]. Asylums sometimes had a patient census that was triple what the institution was designed for. Without the ability to control regimen and moral treatment slipping, asylum care suffered as well. George [5], Superintendent of Worcester State Hospital, comments that:

I cannot sufficiently keep myself acquainted with the various departments to act understandably. I cannot know the daily changes in the symptoms of 450 patients-the operations on the farms and in the workshops...direct the moral treatment...If he [the Superintendent] has in his charge more than one hundred he finds it difficult to know their personal history and the daily changes of their condition. (p. 10)

Chandler’s comments further the idea that with an increase in population within the institution, asylum doctors, as well as all the staff, could do little to help the patients. Grob [13] adds that as institutions grew in size and complexity they transformed to administrative and managerial institutions. With the increase in the patient population, state legislature failed to increase funds as well, thus increasing the burden of the already under-funded institutions [9]. In seeking less expensive methods for treatment of the insane, Gamwell and Tomes [10] write that some legislatures argued for large stripped-down hospitals for chronic patients, while others argued for the idea of cottage or village communities. Moral treatment was dwindling in the asylum. In addition to high census in hospitals and low funds, bureaucracies governed hospitals. Public institutions had little autonomy and their structure, admissions policies and finances were determined by the state legislatures. Gamwell and Tomes [10] write that state lunacy boards implemented inspections and regulations of asylums, and also severely limited the Superintendents right to deny admission to chronic patients. As Superintendents feared, their patient populations started to change to long-term management or custodial.

Perceptions of mental illness during the late nineteenth and early twentieth century changed as well. The idea that mental illness was curable, especially in an asylum, began to change due to the longevity of most patients’ stays. According to Grob [13] many persons simply failed to improve or recover. Gamwell and Tomes [10] suggest that overall, moral treatment failed to actually treat and cure mental illness. The growing number of patients in the hospital ultimately shifted moral treatment to custodial care, thus changing the very purpose of the institution. Custodial care, while necessary for some severely insane patients, is not required for the majority of patients. At this time, however, the state asylum’s role largely shifted to a custodial one.

During the shift to custodial care some asylums created experimental psychology laboratories, thus recognizing the downfalls of moral treatment, to attempt to find cures and treatments for mental illness [10]. One such laboratory created in 1889 at the McLean Hospital attempted to apply empirical research to its patient population. American psychiatrists at this time tended to combine their research with that of European and British psychiatrists. From the early 1890s and on, American psychiatrists started to make original contributions to the field. Ultimately, however, by the late nineteenth and early twentieth century, care for the mentally ill resided in private hospitals, such as the McLean, New York State or The Pennsylvania Hospital, or large state mental hospitals that could only offer custodial care. Over the next 50–60 years the state mental hospital would redesign itself and its role. The first generation Superintendents who insisted on...
moral treatment had now retired or died. Grob [13] adds that second generation Super-
intendents and psychiatrists attempted to reintegrate psychiatry into hospital medicine and
in the process often left out the caring/moral contributions of the first generation. Due to
the increase in patient populations, a decrease in state legislature funding and a change in
the perception that mental illness could be cured in the asylum, the ideas of moral
treatment diminished and state hospitals converted to long term treatment facilities.

Back-wards, Warehouses, Snake pits, Psychotropic Drugs
and Deinstitutionalization

As custodial care took root in many state mental hospitals in America, psychiatrists reex-
amined how mental illness would be treated. The early twentieth century saw the rise of the
mental hygiene movement, promoted by hospital psychiatrists. Grob [13] defines the mental
hygiene movement as the belief that it was easier to prevent mental disorders than to treat
and cure them. Psychology and psychiatry would act as preventative measures. Clifford W.
Beers, the creator of the mental hygiene movement, published A Mind That Found Itself[3].

One of the most powerful scenes is an interaction with his doctor. Beers reflects:

Whether you believe it or not, it’s a fact that I’m going to reform these institutions
before I’m done. I raised this rumpus to make you transfer me to the violent ward.
What I want you to do now is show me the worst you’ve got. ‘You needn’t worry,’
the doctor said. ‘You’ll get it.’ He spoke the truth. (p. 150)

In his book, Beers, a former patient, comments on the lack of knowledge that psychi-
atrists possess, relying on seclusion and straightjackets. Beers also comments on the lack of
consideration, training and caring that attendants had for him [3]. Beers’ book had a
considerable impact by publicizing the abuses that occurred within many institutions
among other injustices. Grob [13] adds that the book called for action eliminating existing
evils and reviving institutional care. In 1909, with help and support from William James,
and Adolf Meyer, Beers founded the National Committee for Mental Hygiene (NCMH)
[13]. The NCMH would serve various functions but with an ultimate goal to protect rights
and improve the quality of care for the mentally ill.

Unfortunately, the mental hygiene movement was not able to give states an additional
option to the state hospital. A formal community type care system did not exist and states
had to rely, heavily, on the state hospital; it was difficult to ignore the great amount of
distress that was occurring with custodial care. Grob [13] gives a startling idea of the
overcrowding in state mental hospitals at this time: in 1910 there was an inpatient popu-
lation of 187,791 and by 1939 it was nearly 425,000. With a doctor ratio sometimes of 1 to
500, and a nurse ratio of 1 to 1,320, there was little treatment that could be properly
administered. Attendants were barely able to keep up with day to day needs. Whether it
was from lack of care, no care, or high use of physical and chemical restraint because of
understaffing, abuses occurred. Beers was one of the first to publicize the abuses that
which also opened the eyes of the public. Ward [32] retells her story through the mental
health system and in the process compares it to no less than a snake pit. An additional term
used to describe the conditions in some hospitals was back-wards: the idea being that many
of the most violent/troublesome patients were left in wards that were the furthest away
from the rest of the hospital. Also, the term warehousing meant storing the mentally ill
with little to no treatment.
During the late nineteenth and early twentieth century radical new therapies were developed and used on patients. Some of these new therapies included insulin therapy, electroshock therapy (electroconvulsive therapy, ECT), hydrotherapy, psychotherapy and lobotomy. Grob [13] points out that with some of these new therapies psychiatrists were not exactly sure why they produced positive results on patients, but continued to use them anyway. While some of these therapies may appear unethical by today’s standards, they were a last resort for patients who did not respond to any other treatment. Psychosurgery for example, specifically the lobotomy, was developed by Egas Moniz and widely popularized by Walter Freeman [13]. Freeman spent much time and effort campaigning that his transorbital lobotomy procedure was successful. The outcomes were mixed, with some producing death, but Freeman claimed the success of the procedure until his death [8].

Realizing that state hospitals had not been as successful as the state legislatures believed, states began creating outpatient care facilities to ease the overcrowded hospitals; thus, leaving the state hospital to treat only chronic patients. It is noteworthy, however, that the state legislatures were fairly responsible for the downfall of the state hospital in their inability to appropriate more funds and the continuing drive to place patients into the burdened hospitals. Nevertheless, by 1945 there was an attempt to shift the care and treatment of the mentally ill from the hospital to the community [13]. The purpose of community-based care originally was to identify, treat and if possible, prevent persons from developing serious mental illness. With the ending of World War II a renewed interest in research on the causes of mental illness began. Psychiatry as a field had to add to the known data that psychologists and sociologists had acquired. Mental health workers also started an overwhelming task of changing public perception of mental illness. Although the public disliked how the mentally ill were treated in hospitals and wanted change, they were hesitant to have the mentally ill treated in their communities. With the National Mental Health Act of 1946, the federal government became the new medium to promote change.

In the 1950s, psychiatrists saw the advent once again of new forms of therapy. Milieu (life space) therapy which encouraged a positive support environment that teaches positive social skills and confidence building and psychotropic drug therapy. In the mid-1950s first generation anti-psychotic medications were developed, such as chlorpromazine (Thorazine) and haloperidol (Haldol) [21]. Anti-psychotic drug treatment, combined with the other forms of treatment listed, supported the concept that patients could indeed get better and leave the hospital.

In 1960, the U.S. Supreme Court ruled on a case that became known as the least restrictive alternative [21]. The ruling, once applied, meant that involuntary commitment to a hospital was only possible if there were no other treatments that would give more freedom to the patient. Levinthal [21] points out that as a result to the Supreme Court ruling, treatment of the mentally ill shifted from the state hospitals to community care. The least restrictive alternative is only one in a series of court rulings that lead to and facilitated deinstitutionalization [22]. With the help of anti-psychotic medications and deinstitutionalization, the inpatient population decreased by nearly 80% over the next 30 years [21]. The hope was that community care could provide a smaller, more humane place to treat the mentally ill. In actuality many consider deinstitutionalization and community care a failure on some levels.

Problems of Deinstitutionalization and the State Hospital Today

Deinstitutionalization decreased the population of most hospitals in America, which limited available treatment. However, there was considerable failure in the process as well.
Levinthal [21] points out that there was minimal planning to prepare for deinstitutionalizing hospitals. Additionally, community care failed to meet the expectations of mental health professionals. It was not able to provide for the treatment and care of the extraordinary numbers of patients discharged. Bigby and Fyffe [4] comment that perhaps too much attention was given to the institutions that were closing and releasing patients, and not enough attention to the community care system as a whole. The concern is a valid one; the closing of hospitals and releasing of many patients displaced hundreds of doctors, nurses and staff that additionally became concerned with their own burden instead of the patients’. Community care also had difficulty providing for the safety of the patient and the community. Lamb [20] reports that it is becoming increasingly difficult to treat patients with psychosis in community settings due to the lack of structure as compared to the structure of the state hospital. Marty and Chapin [22] write that patients have rights in the community as well as in an inpatient setting, including the right to freedom from harm and community mental health providers are ethically bound to provide this. As stated before, an additional positive outcome of deinstitutionalization was believed to be a less costly alternative to state hospitals and an increase in the quality of care. Anyanwu [1] concluded, however, that there is no significant difference in costs or in the quality of care between that of the state hospital and community-based care. Community mental health providers additionally do not operate under a national set of standards to insure quality of care and treatment [22], whereas state hospitals operate under the Joint Commission on Hospital Accreditation. Whether deinstitutionalization was a success or a failure, its outcomes are real and present. Levinthal [21] reports that an estimated one-third to one-half of all homeless persons are currently suffering from severe mental illness. Known as the revolving door syndrome, many patients discharged from state hospitals only remain out of hospitals a short time, and then return again either to a hospital or jail.

The state hospital today survives with the purpose to care for long-term chronic mentally ill patients as well as an acute treatment center, providing inpatient care for patients from days to a few months. Many state hospitals provide some of the same services that the community does, such as day treatment programs. Nevertheless, the state hospital’s ultimate goal is to discharge patients (if able) back into the community to live on their own or in the least restrictive environment. From the time a patient enters the hospital; treatment teams prepare for his/her discharge, and in the process, treat and stabilize patients so that they may live with some level of autonomy. State psychiatric hospitals today are adopting what Smith and Bartholomew [26] call the recovery model. Traditionally state hospitals operate under the medical model: one that promotes the treatment of symptoms, pathology and illness. The recovery model promotes the idea that recovery is possible and should be a goal of all patients. Additionally, the recovery model empowers the patient to strive toward therapeutic goals and wellness [26].

Conclusions

This author concludes with the thought that America has indeed nearly returned to its previous state, and a time where the mentally ill are treated in jails, prisons, poor houses or left on the streets. With the closing of many state hospitals in America the mental health system is broken. As previously stated, community care is not able to handle serious and chronically mentally ill persons. Earley [7] sums up the situation nicely in his book Crazy: A Father’s Search Through America’s Mental Health Madness. Earley [7] writes that between 1955 and 2000 the number of persons being treated in hospitals dropped from
560,000 to around 55,000. Today there is an estimated 300,000 being treated in prisons, with the LA County Jail being the largest public mental health facility in America. In Virginia, the Joint Commission on Health Care reports that regional and local jails house 59% of persons with mental illness versus 23% in state hospitals [12]. Today, back-wards, no longer applies to the outermost wards for disturbed patients; it the state of our mental health system. It is indeed, backwards, and regressing further.

From jails to asylums, to state hospitals and community care, the care of America’s mentally ill has been tumultuous. The role of the American state hospital has been pivotal in how Americans treat their mentally ill. It is difficult to deny that Americans did not have the most benevolent of intentions in creating public asylums, especially with the trends of their times. Did Kirkbride’s linear plan fail? It is difficult to say, as Yanni [34] points out, because it was never carried out fully as he intended. While our presentist thinking (see [11]) may look at the asylum founders with scorn, those founders were treating mental illness with every available option of their time, just as we are today. Grob [13] writes that many psychiatrists today would rather just forget parts of the history of their field. If one is so ashamed of his or her past history, he or she needs not forget it or deny it, but work to improve the future of the field. Genuine caring for mentally ill persons is a treatment option that will always be needed. Perhaps in the future the state hospital will re institute therapeutic beauty for the benefit of the patient, which has long since been overlooked. Legislatures would do well to remember the history of the state hospital. As the state hospital will continue to provide services, in some capacity, to America’s mentally ill for some time to come, it is important to not repeat the offenses of the past. Not providing funds, decreasing beds and overcrowding state hospitals will not make them go away, but only leave hospitals in a vicious, 200 year old cycle.

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