Deinstitutionalization and Reinstitutionalization of the Mentally Ill

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INTRODUCTION

In modern history, three great shifts in concepts and practice in the treatment of the mentally ill are recognized. The first “revolution” followed the political and intellectual liberation of humans arising from the struggles of the French Revolution. Its counterpart in the mental hospitals of the day was moral treatment, a philosophy expounded by Philippe Pinel, which emphasized kindness, forbearance, and a personalized approach to patients. Pinel claimed that the mentally ill generally did not demonstrate recognizable lesions of the brain and would respond to enlightened tolerance and understanding without the necessity of chains, straitjackets, or other punitive measures. His philosophy spread throughout Europe and then to America, where the early hospitals, founded on principles of moral treatment, boasted gratifying therapeutic results even in seriously ill patients. Indeed, Parke’s remarkable follow-up of patients admitted to the Worcester (Massachusetts) State Hospital, the first of its kind in the nation, showed that the majority of persons admitted with less than a year’s evidence of mental illness eventually could be discharged as recovered.

History also records that after 1855, with the introduction of the Industrial Revolution in American society, moral treatment declined and faded away. It gave
place to increasingly custodial management of the mentally ill, with consequent long hospitalization, poor prognosis, and sometimes lifelong stigmatization.3–7

During the first half of the twentieth century, a second revolution, often characterized as the Freudian enlightenment, swept through the Western world. It moved from the private consulting room, where mostly neurotic patients were treated, to the mental hospitals, where primarily psychotic patients were in custody. Whereas Pinel emphasized removal of punitive physical restraints, Freud emphasized release from the unconscious mental barriers that shackled the minds of men and women. Exploration of the individual’s most intimate thinking and feeling became central in understanding the psychodynamics of the individual’s behaviors and in “working through” the patient’s unwholesome defenses.

In the 1930s and 1940s, the Freudian approach competed with somatic therapies—shock, insulin, and psychosurgery; in the 1950s, Freud’s psychoanalytic approach had to contend with the new discoveries in psychopharmacology, especially as applied to the treatment of psychotic individuals.

The third revolution,8–9 ushered in after World War II and still in force, appears to be a mixture of social and community insights into the etiology and treatment of emotionally impaired persons, together with a massive development of research and clinical innovations constituting a new behavioral science. It not only views the individual as shackled by social injustice and distress—unemployment, urban crowding, family dismemberment, poverty, discrimination against minorities, and socially deviant lifestyles; it also addresses systems of delivery of care and treatment. Even more, it attempts to confront the larger public health challenge of providing adequate and appropriate services to all the individuals in need within defined geographic boundaries. In the context of this third revolution, the deinstitutionalization movement was born.

THE DEINSTITUTIONALIZATION MOVEMENT

For many years, the abuses of patients and the inadequacies of treatment in the nation’s large and remote mental hospitals had weighed heavily on the consciences of enlightened citizens. In his 1948 book, aptly titled The Shame of the States, and again in 1949, Albert Deutsch10–11 proclaimed the U.S. mental health system to be a national disaster. World War II taught the nation that a large percentage of its young adults were unfit to serve in the armed forces because of mental illness; even those who were accepted for service often were incapacitated emotionally by the strains of combat.12–13

In 1955, the Joint Commission on Mental Illness and Health was organized, under the aegis of the American Psychiatric Association, to recommend a national policy of reform.14 In its final volume, published in 1961, the Commission stated that treatment of the mentally ill in the United States was a national disgrace. It recommended a doubling and tripling of funds for the mentally ill; training in many more professions, especially in the core disciplines of psychiatry, psychology, nursing, and social work; and phasing down the populations of the large mental hospitals. The Commission called for a massive increase in basic research and clinical innovation.

Perhaps the most important recommendation by the Joint Commission was that the nation be divided into circumscribed population areas of 75,000 to 200,000 persons, with a single authority assuming responsibility for the mental health of a person’s given area. That authority would plan and implement services for all the