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THE DEINSTITUTIONALIZATION OF THE MENTAL HOSPITALS AND THE MOVE TO COMMUNITY MENTAL HEALTH CENTERS

Focusing on Wisconsin in the 1980s

History 489: Research Seminar

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Abstract

This paper focuses on the changes in the care and treatment of the mentally ill population in the United States. It specifically focuses on the time period between the end of World War II through the 1980s. This time period is interesting because there was a massive movement of mentally ill patients out of the mental institutions and into community based centers. This paper attempts to provide the reader with information to explain the reasons for the deinstitutionalization of the mental hospitals and to demonstrate the changes in care for the mentally ill as they were moved into community health centers.

Introduction

The care and treatment of mentally ill patients has changed numerous times throughout history. Beliefs in whose responsibility it was to look after and care for the mentally ill has also changed. In the earliest years of America's existence it was the immediate family who was responsible for the care of a mentally ill family member. As the communities grew, more and more of that responsibility was taken on by others. Eventually, mentally ill patients were committed to mental institutions or asylums. Changes in technology, knowledge, and beliefs in civil rights then called for the deinstitutionalization of the insane asylums. The move from these asylums to a more community based practice came with many problems and successes. This paper will attempt to break down the reasons for deinstitutionalization and demonstrate the changes in policies, laws, and the treatment and care of the mentally ill as they were moved into community based settings after World War II through the 1980s. I will use Wisconsin as an example in order to demonstrate some of the changes in laws regarding the mentally ill populations in Wisconsin. Unfortunately I am limited in my resources since there are no documents regarding the mentally ill in Wisconsin before the late 1970s. Therefore, I have used documents from the 1980s to show what happened in Wisconsin.

Brief History of Mental Health Care in America

In colonial America, care for the mentally ill was much the way it had been for centuries. Families took care of their ill family members. The population was small and scattered and everyone in the community needed to work to help each other to supply and secure things like food and shelter. Mental illness was perceived to be a personal problem, as opposed to a community/social issue; therefore it was the family's duty to look after them.[1] In a few cases, small communities took part in the care of a mentally ill member.[2] There was little time to learn how to care for or help mentally ill persons in the community and the numbers of mentally ill people was relatively small so special facilities were not "required" or even thought of.[3]

As time went on and the population grew there were more and more people able to take care of the mentally ill. Near the beginning of the 1700s the first institutions for the mentally ill began to show up in larger towns. These "institutions" accepted a wide range of people who needed care such as the very young, the very old, and the mentally ill. These almshouses provided care as a way to "fulfill humanitarian and moral obligations."[4] In many ways, the asylum was seen as a safe place for the "disordered mind" to be "mastered" and, following Michel Foucault's ideas, the unreason would fall into reason.[5] Some superintendents envisioned the asylums as "re-creations of the idealized colonial community" where the environment itself was therapeutic and it would reduce the stresses of social life and provide "order and stability" for the patients.[6]

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[1] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 5.

[2] Ibid. p. 7.

[3] Ibid. p. 6.

[4] Ibid. p. 17.

[5] Perrucci, Robert. *Circle of Madness: On Being Insane and Institutionalized in America.* Englewood Cliffs, NJ : Prentice-Hall, Inc., 1974, p. 11.

[6] Ibid. p. 13.

Increased urbanization of larger cities began to redefine the roles of society and the individual families. With an increased population the larger numbers of mentally ill people were starting to be seen as a threat. The notion that families could and should take care of their mentally ill members began to change. Mental hospitals began to show up in many of these larger cities and took on many of the responsibilities that the families once had.[7] These mental hospitals were, however, unequipped to meet the demand of the population. By the middle of the nineteenth century insane asylums began to take over the care and treatment of the mentally ill. These asylums were set up and administered by the state.[8] Larger cities had at least one asylum, but often had many more. In 1860, 28 of 33 states had institutions, a huge increase.[9] For the most part though, these institutions were used by the more wealthy people in the city.[10]

Asylums were championed because of “early claims and achievements”. This gained many supporters. Asylums took in people from all walks of life. The rich and the poor were both treated to the best of the institutions ability. The goal of the asylum was to cure the mental illness, but if they could not, then they would provide “humane custodial care”.[11] On the other hand though, asylums made the physician the “central and ultimate authority for the care and treatment of the mentally ill.”[12]

Reasons to institutionalize a person varied. It was generally a very difficult decision to commit a family member, but in some cases caring for the mentally ill at home was very difficult

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[7] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994,p. 24.
[8] Ibid. p. 40.
[9] Perrucci, Robert. *Circle of Madness: On Being Insane and Institutionalized in America.* Englewood Cliffs, NJ : Prentice-Hall, Inc., 1974, p.11.
[10] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 53.
[11] Ibid. p. 79.
[12] Perrucci, Robert. *Circle of Madness: On Being Insane and Institutionalized in America.* Englewood Cliffs, NJ : Prentice-Hall, Inc., 1974, p. 9.

and caused a lot of tensions. Many families opted to institutionalize members if their primary caretakers, who were usually the parents, died. In many cases siblings were not able to take care of the mentally ill and therefore decided to have them placed in an asylum. While many believed committing a mentally ill person to an asylum was a strictly legal and complex process it really was based on "human decisions" instead.[13] This allowed for many wrongfully committed individuals. Asylums were also plagued with overcrowding of inmates, lack of funding, deteriorating buildings, and many untrained nurses and attendants.[14] For these and many more reasons, it was realized that there was a much larger gap between the ideals of asylum life and what was really happening.

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[13] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994,p. 80-81.
[14] Ibid. p.82.

Care and Treatment of the Mentally Ill

The care and treatment of individuals with a mental illness has changed drastically throughout history. Before 1800 there was little written about the treatment or therapies to be used in the care of mentally ill individuals. At the time, most of the emphasis was put on the "nature" or the causes of the illness rather than how to fix it. Most "treatments" at this time were used only to keep order in the community or to ensure that outbursts were dealt with quickly.[15] Before the 1800s there was the belief in the Galenic humors. According to this tradition, diseases were caused by one of the four humors; blood, yellow bile, black bile, and phlegm. Too much or too little production of these humors was thought to be the cause of diseases and illnesses. Causing a patient to bleed or throw up were the most common therapies or treatments. There was little distinction between a mental and a physical illness, so both treatments were used.

This was also a time when diseases and illnesses were thought to be brought on by supernatural forces. The cures for these could be found in religion or magic. Because of this many mentally ill patients were brought to ministers or women, instead of doctors, to be treated.[16] It was believed that Satan could tempt people into madness or insanity by "exploiting their moral weaknesses". Madness, then, could be cured by confession.[17]

At the very end of the 1700s a French man named Philippe Pinel came up with a method of "moral treatment". Moral treatment was designed to gain the trust and confidence of a mentally ill patient and instill hope in them. He believed that environmental changes could affect a person's mind and therefore could change their behavior. To do this, a person needed to be confined in an institution or an asylum so they could "internalize" the normal society's values

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[15] Ibid. p. 7.
[16] Ibid. p. 9.
[17] Ibid. p. 10.

and behaviors.[18] This was thought to "cure" a person of madness. This method was also seen as more humane since it did not involve bleeding or forced purging. This seems to be the beginning of our more modern therapies.

Therapies can be divided into two groups. The first group is psychotherapies. These are less radical and are more like earlier treatments of the 1800s, including moral treatment, behavior modification, and group interaction. These forms of treatment emphasize humane treatment and psychologically positive interactions. The second group is called somatic therapies, which include treatments like shock therapy, lobotomy, and chemotherapies like narcotics and sedatives used as powerful tranquilizers.[19]

In 1928 a physician, Manfred Sakel, developed a technique of treating diabetic drug addicts with insulin. In the 1930s he began to use insulin on schizophrenics. The basic idea was to give enough insulin to lower the blood sugar levels of the patient to cause them to go into a coma. Then all one had to do was give that patient some sugar and they came out of the coma. It was claimed that this type of shock therapy was "highly effective in the treatment of mental illnesses."[20]

Soon after insulin therapy became popular another shock therapy was being developed by Ladislas von Meduna for use on schizophrenics. He used metrazol in order to induce convulsions because he noted that "epileptics rarely became schizophrenic."[21] Because of the risks associated with insulin and metrazol therapies, such as pulmonary edema, epileptic

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[18] Ibid. p. 27.
[19] Peterson, Dale., ed. *A Mad People's History of Madness.* Pittsburg, PA : University of Pittsburg Press, 1982, p. 240-242.
[20] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 180-181.
[21] Ibid. p. 182.

seizures, broken and fractured bones, and respiratory problems, electro-shock therapy quickly replaced these treatments.[22]

Electroshock was believed to be effective in "reversing severe depression". It was thought to be "therapeutic and painless". This led to its indiscriminant use for treating many different mental disorders.[23]

The lobotomy was invented in the 1935 by Egas Moniz. It was seen as a "relatively simple surgical procedure that involved severing the nerve fibers of the frontal lobes of the brain."[24] Originally to do this, holes were drilled into the skull and a needle was used to inject a "cell-destroying alcohol." This method was not very efficient and the alcohol sometimes spread to other areas not intended. Later, a hollow needle with a "retractable wire loop" was inserted through the holes and was used to cut a small core of tissue from the frontal lobe. This procedure of cutting cores was done 4 to 6 times.[25] This was seen as the most radical of the somatic therapies because the effects were irreversible and "the outcome not always predictable."[26]

The use of the lobotomy was not widespread at first because of WWII, but soon after the war many patients underwent this "psychosurgery." From 1936 to 1951, 18,608 patients received lobotomies; in 1949 it peaked with over 5,000 operations.[27] Many of the patients that were seen as "highly disruptive or intractable" became more "manageable" and adapted to

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[22] Ibid.

[23] Peterson, Dale., ed. *A Mad People's History of Madness.* Pittsburg, PA : University of Pittsburg Press, 1982, p. 241.

[24] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 182.

[25] Peterson, Dale., ed. *A Mad People's History of Madness.* Pittsburg, PA : University of Pittsburg Press, 1982, p. 241.

[26] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 183.

[27] Ibid.

institutional life better after having a lobotomy. The problem was that there were significant alterations in the patient's personality. Gosta Rylander observed that patient's emotions were "dulled" and

> they were subject to paroxysms of rage; they became tactless and distractible; intellectually they could neither synthesize nor think abstractly; they showed poor judgment and impaired retention; their ability to work was diminished; and they manifested exaggerated emotional responses.[28]

The results of a lobotomy were "erratic and unpredictable".[29]

With the introduction of so many new "therapies" theoretical issues began to arise. In the case of insulin therapy, Sakel even admitted that there was no rational reason for why this treatment worked. It seems that the outcome was able to justify its use. Questions about whether or not physicians should be able to use experimental therapies on patients began to arise since some of these experiments left patients worse off than before. When testing the effectiveness of the various shock therapies many of the studies lacked a control group, many of the samples were too small, and there were no standardized criteria on which to evaluate the patients.[30] Also, the lack of knowledge about the long term effects of these treatments was unknown. It did not seem right for patients to be experimented on like this. On the other hand though, many of these mental hospitals had huge populations of chronically mentally ill patients who were probably destined to live their whole lives in the asylum. If there was a treatment that could lead to a cure, then why should physicians wait until there was "conclusive evidence?"[31]

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[28] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 186.
[29] Peterson, Dale., ed. *A Mad People's History of Madness.* Pittsburg, PA : University of Pittsburg Press, 1982, p. 242.
[30] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 185.
[31] Ibid. p. 181.

What led to deinstitutionalization?

Mental hospitals throughout the United States seemed to have more and more problems as time went on. The lack of funding for hospitals and asylums had plagued them since the beginning, but now there were increasing problems with things like staff members and deteriorating buildings. Many outside forces also contributed to the popularity of deinstitutionalizing of the mental hospitals. Increasing knowledge about therapies and treatments led to questions about how to best help the mentally ill patients.

John A. Talbott, M.D. attempted to summarize the problems of the state mental hospitals by grouping them into the main areas of concern that he experienced through his research. One of the most obvious problems of the hospitals was the buildings themselves. Throughout the United States, most of the buildings were very old and falling apart. They were seen as outdated and "inflexible" so the stigma was that they could only be used as an institutional setting. Talbott argues that they were designed for "safety and structure" instead of for "programs and function".[32]

The staff members were also seen as a large problem of the hospitals. While Talbott does not mention any of the beatings or cruelties that have been cited before, he does say that they are "frequently less educated and less well trained than their counterparts in community hospitals."[33]

The most common problem was the lack of funding. Overcrowding, deteriorating buildings, low status, lack of legislative support, and lack of a constituency (all problems of their own) led to lack of funding and made this problem almost overwhelming. It seems there was no way out of this hole.[34]

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[32] Talbott, John A., ed. *State Mental Hospitals: Problems and Potentials.* New York: Human Sciences Press, 1980, p. 22.

[33] Ibid, p. 23.

[34] Ibid. p. 26.

In addition to the internal problems of the mental hospitals, there were many outside influences that led to the deinstitutionalization of the mental hospitals. The Great Depression caused many asylum superintendents to reduce spending on things like libraries and other services that were less essential in order to maintain a food budget.[35] Since institutions were unable to expand with increasing demand asylums became extremely overcrowded during the Great Depression. Towards the end of the depression, the average daily population in these asylums exceeded capacity by 10.6%. In some states the capacity was exceeded by 40%.[36] World War II caused the overcrowding of the mental hospitals to increase to 16% because more money was put into wartime efforts.[37]

It has been said that, "more than any other event, World War II was the catalyst of change."[38] Before being sent to war, soldiers were "screened" to test their mental faculties. This was done as an attempt to reduce their risk of developing some sort of mental illness that would prevent them from fighting or impair their lives after the war. Personal interviews, tests, and the social histories of the individuals were examined as a way to predict mental disorders, but these methods of screening proved to be ineffective.[39] World War II showed scientists and physicians that environmental stresses/factors played a much larger role in mental illness than previously believed, and predisposition was "not a significant factor."[40] This meant that all individuals could be at risk of developing a mental illness.[41]

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[35] Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill.* New York : Free Press, 1994, p. 169.
[36] Ibid. p. 170.
[37] Ibid. p. 70.
[38] Ibid. p. 191.
[39] Ibid. p. 192.
[40] Ibid. p. 193.
[41] Ibid. p. 194.

During World War II many institutional problems were overlooked by the government and the community because there was so much focus on the war. During this time it was extremely difficult to get US citizens to focus on anything other than the war. Many different tactics were involved including articles, books, photographs, and even movies to draw attention to the problems in the mental institutions. One journalist, Albert Deutsch, claimed that Detroit "pays less attention to its humans, sick in the mind, than it does to its machines. I have seen animals better treated and more comfortably housed in zoos than are the mentally sick inmates of Detroit's institution, which is not even an asylum much less a hospital."[42]

After the war, some of the soldiers who participated in it were soon seen to have neuropsychiatric disorders that were far more serious than had been recognized before. Physicians realized that early treatment, not in an institution, proved to have positive results. Treatment in civilian, community settings seemed to prevent far more serious mental problems than an institution. This led to the beginning of the push for a dramatic change in the mental health system; a move from institutions to communities.[43]

By 1945, several mental institutions had grown to the size of a small city, the largest ones, New York Central Islip State Hospital, Georgia State Hospital, and Pilgrim State Hospital in New York, had 7,000, 9,000, and 10,000 patients respectively. These institutions were plagued by poorly trained nurses and untrained attendants. They were run by self-proclaimed "superintendants" which showed that there was more concern for how the institution was run (business like) and less for the care and treatment of the patients. This was a time when more and more was being told about patient "beatings, overt abuse, and tyranny over patients." Alfred

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[42] Ibid. p. 202.
[43] Ibid. p. 191-192.

Deutsch compared his two-year survey of several mental institutions throughout the US to the images of Nazi concentration camps, which was still fresh in the minds of society.[44]

It seems like most of the layouts of the mental institutions and restraints used for controlling "unruly" patients were designed to humiliate and break an individual of their identity. Many different restraints were used to try to control mental patients. Wet packs and straitjackets were seen as humiliating by the patients.[45] In some asylums the walls, floors, curtains, etc. were damaged and dingy. Bathroom stalls did not have any doors. Clothing was numbered and often dirty. There was not enough mattresses or cots, bed linens, toilet paper, or changes of clothing for the patients.[46]

As a result of new federal social and economic programs in the 1960s, there was a much more optimistic atmosphere. It was believed that "most social problems could be found in a deficient environment." This led to a more community based ideology and the belief that all individuals and groups should be involved in all of the decisions that affect their lives.[47] The community mental health centers seemed to fit into this description much better than the institutions because there was more sense of autonomy.

Deinstitutionalization was officially defined by the Director of the National Institute of Mental Health as

> (1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment, (2) the release to the community of all institutionalized patients who have been given adequate preparation for such a change,

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[44] Peterson, Dale., ed. *A Mad People's History of Madness.* Pittsburg, PA : University of Pittsburg Press, 1982, p. 238-239.
[45] Ibid. p. 244.
[46] Ibid. p. 244.
[47] Grob, Gerald N. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton: Princeton University Press, 1991, p. 241.

> and (3) the establishment and maintenance of community support systems for noninstitutionalized people receiving mental health services in the community.[48]

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[48] Torrey, E. Fuller. *Nowhere To Go: The Tragic Odyssey of the Homeless Mentally Ill.* New York: Harper & Row, 1988, p. 4.

What happened to the mentally ill after deinstitutionalization?

Community mental health centers were seen as a "superior" alternative to the mental hospitals in the 1960s. They were a way for mental health services to expand and they diminished "sole reliance upon mental hospitals." These community centers were intended to identify symptoms of mental illness early, provide preventive treatments so that the illness did not worsen, and finally, continue to work with the mentally ill in the community.[49] These objectives completely failed.

The biggest problems with deinstitutionalization can be summed up in eight aspects. E. Fuller Torrey laid these problems out as follows,

> 1. There are at least twice as many seriously mentally ill individuals living on the streets and in shelters as there are in public mental hospitals.
> 2. There are increasing numbers of seriously mentally ill individuals in the nation's jails and prisons.
> 3. Seriously mentally ill individuals are regularly released from hospitals with little or no provision for aftercare or follow up treatment.
> 4. Violent acts perpetrated by untreated mentally ill individuals are increasing in number.
> 5. Housing and living conditions for mentally ill individuals in the community are grossly inadequate.
> 6. Community mental health centers, originally funded to provide community care for the mentally ill so these individuals would no longer have to go to state mental hospitals, are almost complete failures.
> 7. Laws designed to protect the rights of the seriously mentally ill primarily protect their right to remain mentally ill.
> 8. The majority of mentally ill individuals discharged from hospitals have been officially lost. Nobody knows where they are.[50]

Mentally ill patients were "dumped" into the communities that were not prepared to take care of so many people. There were far too few facilities and very little aftercare. Once all of

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[49] Grob, Gerald N. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton: Princeton University Press, 1991, p. 239.

[50] Torrey, E. Fuller. *Nowhere To Go: The Tragic Odyssey of the Homeless Mentally Ill.* New York: Harper & Row, 1988, p. 5-6.

the patients were gone, the hospitals shut down, so there was no place for the severely mentally ill to return to.[51] When the mental hospitals shut down some of the mentally ill patients were able to move into low-income housing units. In the 1970s, many of these units were converted into condos, again kicking the mentally ill out of their residences.[52]

Public officials did not really know what to do about this increase in demand for housing for the mentally ill. Among the many suggestions were “floating shelters”. Basically, the plan was to convert surplus ships from the war, ocean liners, and barges into housing for the mentally ill population. These would then be stationed at waterfront piers. Though this plan had many critics, it was seen as much more humane than others like the tent city in Los Angeles or the closed subway stations in Washington, D.C.[53]

It is difficult to find an exact figure of how many homeless people there are living in the United States, but the United States Department of Housing and Urban Development estimated that there were 350,000 homeless individuals. Many experts believe this number is too low and suggest that there may be as many as one million homeless people in the US. The estimate given most often, though, is 450,000. It is also estimated that of this homeless population about one third (about 150,000) have some sort of serious mental illness.[54]

With these kinds of living conditions it is easy to understand why so many mentally ill individuals tried to get readmitted to the hospitals or arrested and sent to jail in order to have a bed to sleep on and daily meals. There is no way of proving that these people preformed acts in order to get committed, but in one year about half of the patients released were rehospitalized.[55] In the 1980s a large portion of the patients that were released from the mental hospitals were

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[51] Ibid. p. 4.
[52] Ibid. p. 22.
[53] Ibid.p. 23.
[54] Ibid. p. 8-9.
[55] Ibid. p. 25.

readmitted and rereleased numerous times. In New York City 24% of the patients in the mental hospital there had been admitted ten or more previous times.[56]

At the same time as the mentally ill patients moved out of the mental hospitals many officials from jails and prisons from all around the US said that there was a dramatic increase in the number of mentally ill prisoners.[57] It was said that

> if the public ever becomes fully aware of how often mentally ill individuals with a history of violent behavior are released from jails and hospitals with no mandatory continuing treatment, there will be a mass outcry directed toward the lawyers, judges, and psychiatrists who are responsible for this state of affairs.[58]

It's no wonder that there was a dramatic increase of violent acts since 1961 committed by mentally ill individuals.[59]

The laws in many states claimed that a person could not be involuntarily institutionalized unless they were seen as dangerous to themselves or to the members of the community. The problem with this, and so many other laws, is that the qualifications for dangerous are extremely loose. There is no strict definition for "dangerous".[60] In regards to the changes in the state commitment laws in the 1960s an 70s, it was quoted that "we are protecting the civil liberties of the mentally ill much more adequately than we are protecting their minds and their lives".[61]

In 1963 the Community Mental Health Centers Act went into effect. This act was designed to replace the mental hospitals with "local therapeutic centers." The Act, however, was extremely vague and did not define the services that were expected to be provided by the

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[56] Ibid. p. 14.
[57] Ibid. p. 12.
[58] Ibid. p. 16.
[59] Ibid. p. 17.
[60] Ibid. p. 30.
[61] Ibid. p. 31

community centers.[62] It is argued that the vagueness of the functions of the community mental health centers as well as incomplete definitions of certain terms like "mental illness" led to the ultimate failure of the community centers. Some centers thought they were supposed to provide care and treatment, but others believed they were there in order to prevent mental illnesses.[63] There was also confusion about who exactly was supposed to be served at the community mental health centers. Many people from the general public had begun to use these centers in the post-war years which may have led to confusion of the staff over who they were supposed to work with.[64] Combined with serving wide populations of people and having vague laws to govern them, community centers were able to choose who to serve and how to do it.[65]

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[62] Grob, Gerald N. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton: Princeton University Press, 1991, p. 244.

[63] Ibid. p. 251.

[64] Grob, Gerald N. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton: Princeton University Press, 1991, p. 252.

[65] Ibid. p. 253.

Wisconsin

To get a better idea of what was happening between the end of the second world war through the 1980s I wanted to look at Wisconsin. The biggest problem with this is that there are no accessible Wisconsin government documents that mention the mentally ill population or any laws about how mental institutions were to be run before the mid to late 1970s. This could be for a couple of reasons. One explanation was the lack of information available at the time. Gathering and keeping information was not very accurate and much of it was misplaced; possibly on accident, but in some cases it was probably on purpose. Another reason could have been that there was more interest in other sections of the government that the mentally ill were placed lower on the agenda. In any case, it is extremely difficult to compare what was going on in the state government from WWII through the eighties. Fortunately though, there are plenty of documents relating to mental health in the late 1970s through the 1980s. By looking at these and the changes they suggest, we can get a pretty good idea of what was happened before this time.

In August 1978 questionnaires were sent to all the program directors of community service boards in Wisconsin in order to evaluate the different services that were provided to mentally ill people. The questionnaires also tried to get information about voluntary and involuntary admissions, protective placements, and any changes that may be necessary for statutes, administrative rules, and the state budget. Seventy percent responded to the questionnaire, but some did not answer all of the questions. Some could not be answered because there was no differentiation between expenditures on the acutely and chronically mentally ill. At the time county data systems required "manual retrieval" of the data and there are no "client tracking systems," so there was no way of checking to see what services an individual received from various state and county “agencies”.[66] As in the case of the institutions, funding problems were the biggest problem for the community health centers in Wisconsin and in the rest of the country. Report after report listed lack of funds as their most urgent issue.

The chronically mentally ill populations were the focus for the majority of Wisconsin’s government documents. In 1978, chronic mental illness was defined as:

> Persons whose emotional disabilities are so serious and persistent that, without special support for perhaps indefinite periods of time, they are unable to maintain a stable adjustment to community life. These persons exhibit high vulnerability to stress, deficiencies in coping skills, extreme dependency, difficulty in working in the competitive job market and difficulty with interpersonal relationships. Chronically mentally ill persons may be young and may have been institutionalized for only brief periods. They may also be persons who have resided in institutions for many years.

By this definition of the chronically mentally ill, in 1978, 70% or 38 of the 54 of the boards in Wisconsin were responsible for 6,645 patients. But this number is not very accurate. Aside from not having information from all of the boards, there were about 3,000 chronically mentally ill persons living in Milwaukee County who did not “require” treatments continually, so they were not included in the count.[67]

In 1986, the legal definition for chronic mental illness became more specific and was defined as a:

> Mental illness which is <u>severe</u> in degree and <u>persistent</u> in duration, which (1) causes a substantially <u>diminished level of functioning</u> in the primary aspects of daily living and an inability to cope with the ordinary demands of life; (2) may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support; and (3) may be of lifelong duration. Chronic mental illness includes <u>schizophrenia</u> as well as a wide spectrum of psychotic and other <u>severely disabling</u>

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[66] Wisconsin Legislative Council Staff. *Information on care of the chronically mentally ill in Wisconsin,* by Julie Greenberg. Research Bulletin 79-1. Madison, 1979, p. 1-2.
[67] Ibid. p. 3.

> psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation or of alcohol or drug dependence.[68]

Most later documents do not attempt to define chronic mental illness. United States documents as well as Wisconsin documents only give examples of real people who are chronically mentally ill. This is interesting because it seems that the authors and committee members realized in the 1980s that an extremely low percentage of the mentally ill population fits into these simplified definitions. While I cannot prove it with documents from the forties and fifties, I would assume that around this time there was a call for stricter definitions of chronic mental illness. Before this time, just about anyone could be committed to an asylum as I have mentioned earlier. A stricter guideline of who qualifies as mentally ill and who does not may have helped to keep the hospitals from overcrowding. Then in the late seventies, the pendulum may have swung again when people believed that you cannot fit mentally ill people into a set definition. The concern then turned from what qualifies a person as mentally ill to who can be committed.

In 1980, the Wisconsin Legislative Council Staff called for some changes and additions to the requirements of a person who may be involuntarily committed. In Wisconsin, for a person to be involuntarily committed they have to:

1. Be mentally ill, drug dependent, or developmentally disabled;
2. Be a proper subject for treatment; and
3. Satisfy one of the following three dangerousness standards:
    a. A substantial probability of physical harm to oneself, as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm;
    b. A substantial probability of physical harm to others, as manifested by evidence of recent homicidal or other violent behavior or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm; and

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[68] Wisconsin Legislative Council Staff. *The legal framework for care and treatment of the mentally ill,* by Pam Russell. Staff Brief 86-7. Madison, 1986.

> c. Such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a very substantial probability of physical impairment or injury to the person.[69]

A fourth standard of dangerousness was added in July of 1980. It acted as an alternative to the other three standards and says that a person may be involuntarily committed if he or she:

> Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness…[70]

As a result of the questionnaires many recommendations were made regarding changes for the care and treatment of the mentally ill. These included many responses relating to funding, transition places between treatment facilities/hospitals and nursing homes, and community support programs, and problems with involuntary civil commitments and protective placements.[71]

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[69] Wisconsin. Legislature. Legislative Council. *Mental health law revisions : Chapter 336, Laws of 1979,* by Richard N. Sweet. Wisconsin Legislative Council staff information memorandum; 80-1. Madison, 1980, p. 2.

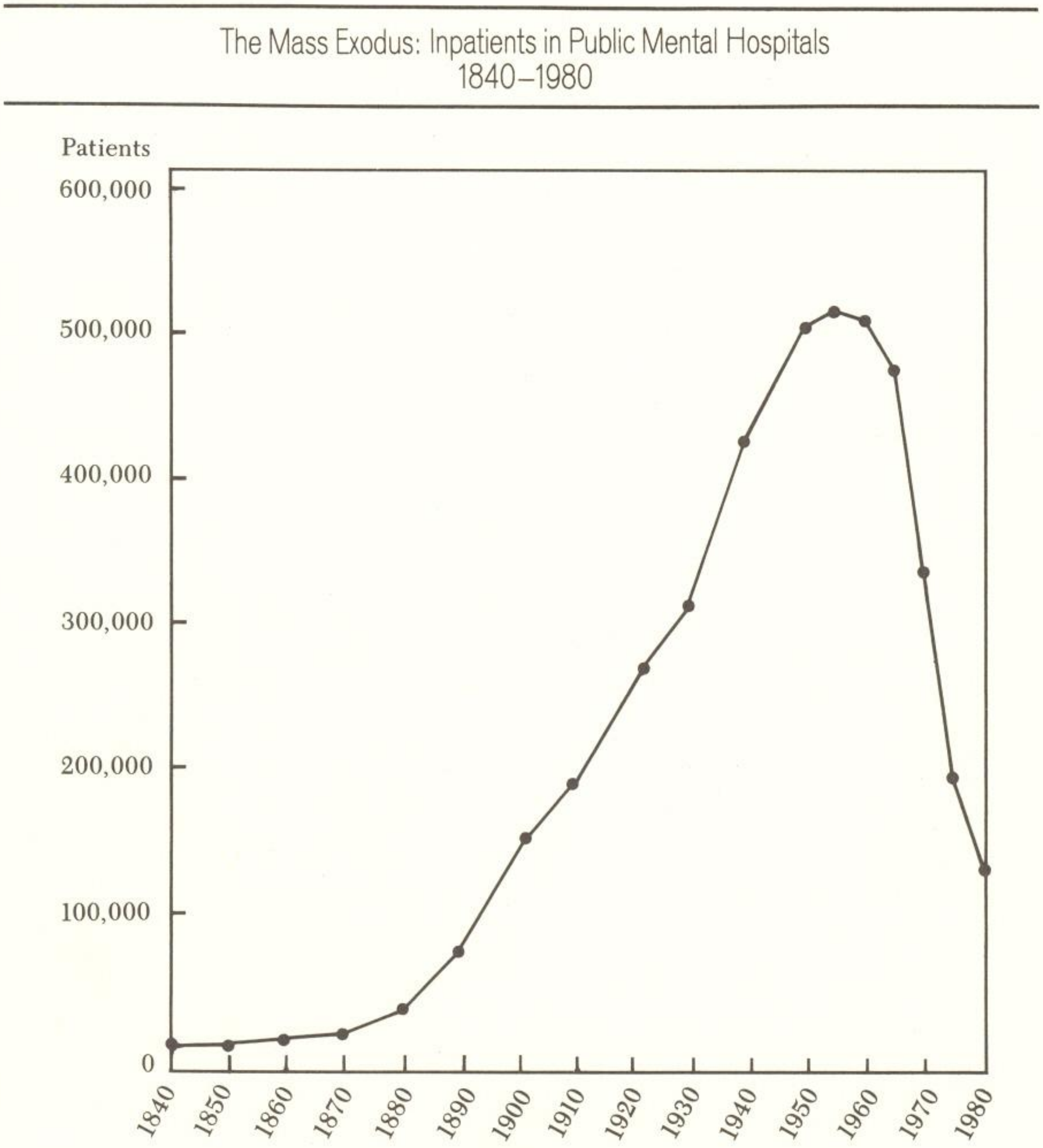
[70] Ibid. p. 3.

[71] Wisconsin Legislative Council Staff. *Information on care of the chronically mentally ill in Wisconsin,* by Julie Greenberg. Research Bulletin 79-1. Madison, 1979, p. 17.

Conclusion

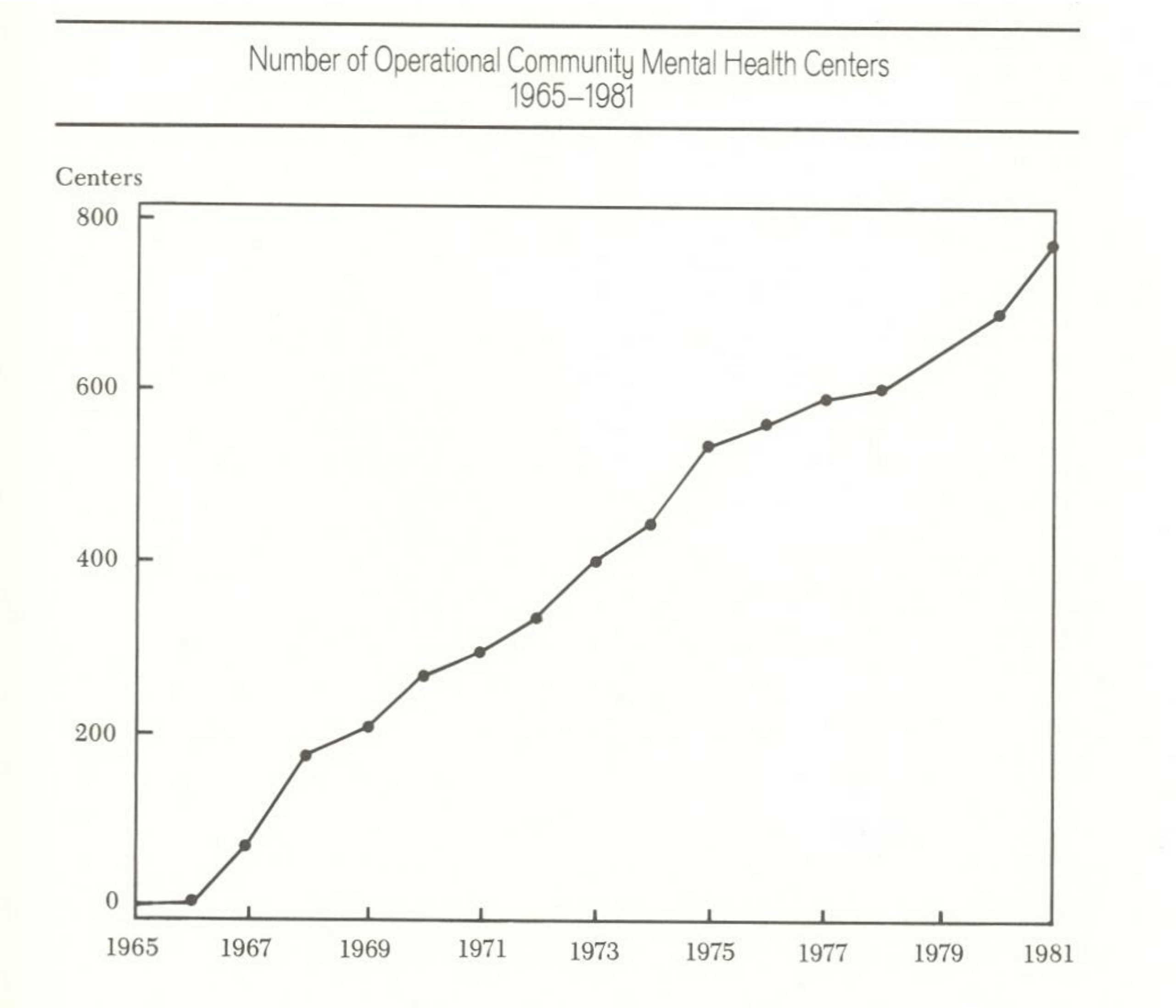
There have been many dramatic changes in the care and treatment of the mentally ill throughout the history of the United States. While families and communities have meant well by trying different approaches and therapies to help mentally ill patients, they have ultimately failed. The move from mental institutions into a community setting, for many reasons, seemed like the best possible thing to do for many of the patients. Unfortunately, due to poor planning and vague laws many of the mentally ill patients released from the institutions ended up without shelter and care. They have been removed from many of the horrible atrocities of life in the mental hospitals such as neglect, beatings, humiliation, and the use of somatic therapies like shock therapy and lobotomies, but they have been transferred into homelessness, starvation, abuse, and have no ongoing care or treatments to help them. In protecting the civil rights of the mentally ill, we have only created an atmosphere that keeps them mentally ill with little chances to reach adequate care and treatments.

Appendix A: The Mass Exodus of Inpatients in Public Mental Hospitals 1840-1980



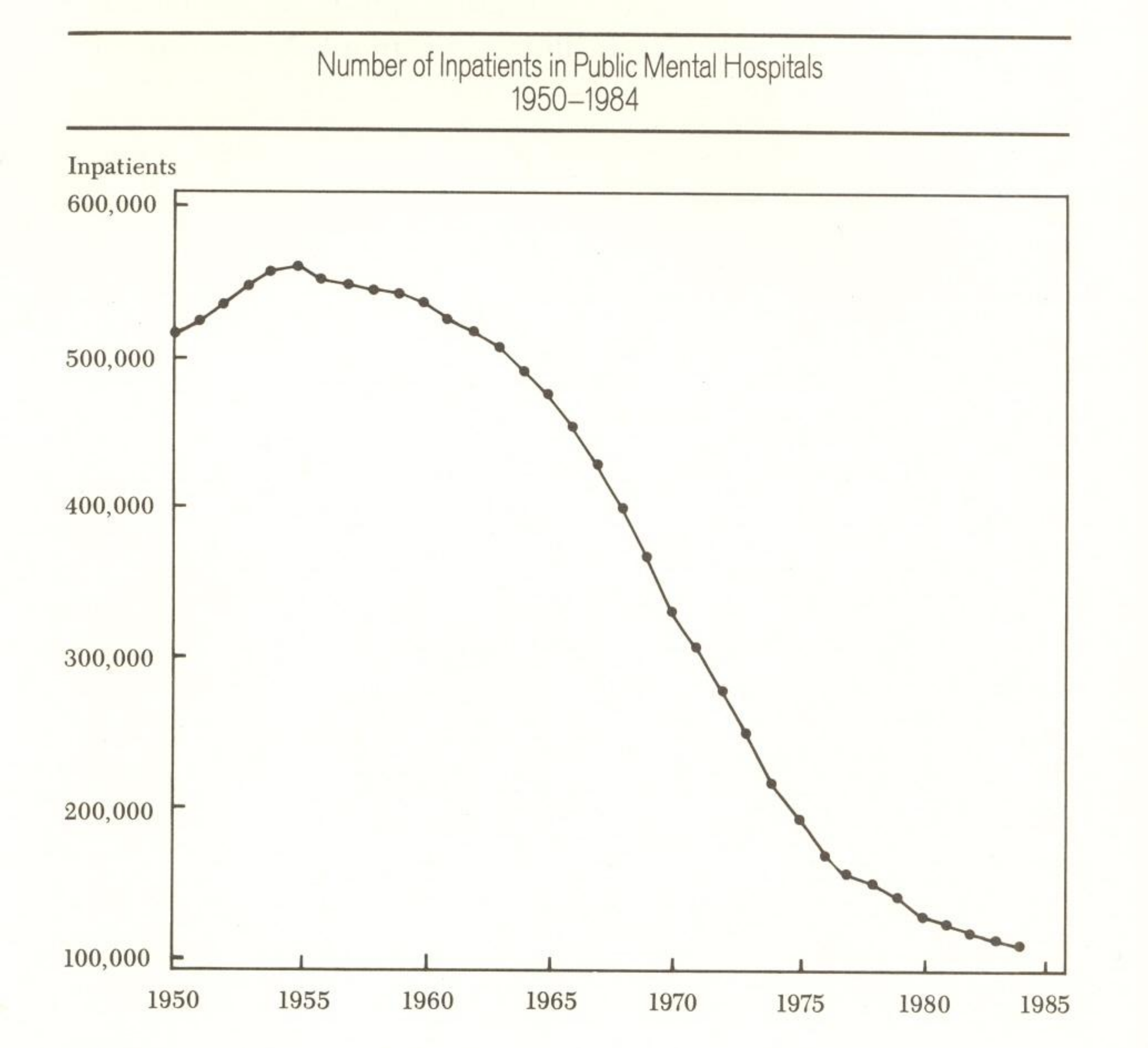
Torrey, E. Fuller. *Nowhere To Go: The Tragic Odyssey of the Homeless Mentally Ill.* New York: Harper & Row, 1988, p. 3.

Appendix B: Number of Operational Community Mental Health Centers 1965-1981



Torrey, E. Fuller. *Nowhere To Go: The Tragic Odyssey of the Homeless Mentally Ill.* New York: Harper & Row, 1988, p. 139.

Appendix C: Number of Inpatients in Public Mental Hospitals 1950-1985



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